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Evaluation of the CHAMPUS Reform Initiative

Volume 6, Implementation and Operations

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National Defense Research Institute

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Prepared for the
Assistant Secretary of Defense (Health Affairs)

National Defense Research Institute

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PREFACE

In an attempt to improve health care delivery and contain cost growth, the Department of Defense (DoD) in 1987 proposed the CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) Reform Initiative (CRI). In February 1988, DoD awarded a contract to Foundation Health Corporation to conduct a CRI demonstration program in California and Hawaii. In authorizing this demonstration program, Congress mandated an independent evaluation of CRI, which RAND was asked to perform. This report describes the implementation, organization, and operations of the CRI demonstration program and relates significant issues that arose in the first two years of the demonstration. It is intended to provide context to readers of the documents reporting the evaluation's results and to inform those considering or facing the implementation of similar initiatives elsewhere.

This is the sixth volume in a series of reports from the CRI evaluation. The other reports are

- Volume 1, Executive Summary
- Volume 2, Beneficiary Access to Care and Satisfaction
- Volume 3, Health Care Utilization and Costs
- Volume 4, Patterns of Medical, Surgical, and Obstetric Care
- Volume 5, Patterns of Mental Health Care.

The CRI evaluation project was conducted for the Assistant Secretary of Defense (Health Affairs) by RAND's Health Sciences Program and Defense Manpower Research Center; the latter is part of the National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, and the defense agencies.

SUMMARY

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pays for much of the health care that dependents of active-duty personnel, military retirees and their dependents, and survivors of deceased service members get from civilian providers. In response to growing costs in CHAMPUS and dissatisfaction with the program on the part of its beneficiaries, the Department of Defense (DoD) proposed in 1987 a set of reforms based partly on civilian managed-care plans. The CHAMPUS Reform Initiative (CRI) makes reduced cost sharing available to beneficiaries in exchange for restriction of physician choice to a specified provider network offering discounts for its services. CRI improves coverage of preventive care and reduces paperwork for beneficiaries, introduces comprehensive utilization review, and promotes better coordination of civilian-provided care with care in military treatment facilities (MTFs). To aid in cost control, CRI is managed by a single contractor responsible for all CHAMPUS costs and thus at financial risk if those costs should grow at rates faster than anticipated.

Since CRI fundamentally changes the Military Health Service System (MHSS), Congress required a demonstration to test the initiative's feasibility and cost-effectiveness before nationwide implementation. The demonstration began in California and Hawaii in February 1988 and, following its planned five-year run, was continued indefinitely. Congress also mandated an independent evaluation of the CRI demonstration. RAND was asked to perform that evaluation.

In the current volume, we describe the implementation and first years of CRI operations, the period of February 1988–December 1990. From numerous interviews with personnel from the organizations involved and review of pertinent documents, we identify achievements, problems encountered, and adjustments to correct those problems and thereby fulfill the demonstration's goals. We also draw lessons that are relevant to implementing managed health care elsewhere in the MHSS.

By the end of the six-month implementation period, August 1988, the contractor and subcontractors began operating the Standard CHAMPUS plan and the new managed-care plans in the major catchment areas (i.e., military-hospital service areas) of California and Hawaii and in all catchment areas by the end of the fifth operational year. The two new plans—a health maintenance organization (HMO) and a preferred provider organization (PPO)—provided care through the MTFs and a single network of civilian providers who agreed to discount their rates.

Within the first 18 months of operations, the contractor also established three key operational features of CRI—an individual (the Health Care Finder) who would be responsible for directing CHAMPUS beneficiaries to the most cost-effective health care setting, an office (Service Center) within the MTF to promote and coordinate efficient working relationships among staff charged with executing CRI, and a process (resource sharing) so that MTFs could be utilized at optimum capacity.

These components eventually operated as planned. However, early in the demonstration the compressed implementation period, an inadequate claims processing system, and faulty con-

tractual language that prevented implementation of resource sharing created problems that prevented optimal execution of many of the managed-care features of the demonstration.

The six-month implementation period was insufficient for adequate education of beneficiaries, civilian providers, MTF staff, and others in the MHSS to master the complex CRI program. Establishing effective communication channels and working relationships with the numerous CRI participants took more time than was envisaged.

The inability of the contractor to efficiently process the claims for the Prime plan enrollees and those using the network providers under the Extra option caused beneficiaries, physicians, and MTF staffs considerable frustration and disillusionment. The subsequent involvement of MTF staff with CRI claims problems evoked criticism from them of the initiative.

The preoccupation by the contractor with claims issues of beneficiaries and providers, and with maintenance of the discounting provider networks, prevented active review of beneficiary medical service utilization and provider practice patterns until later in the demonstration period. Much of the information for these reviews was to have come from processed claims. The inadequate claims system could not provide these data for quite some time. Full implementation of an aggressive utilization review program had to be deferred as well as the corollary quality assurance oversight.

The late implementation of resource sharing disappointed MTF staff who hoped that it would provide resources to increase utilization of their hospitals and clinics. Once the contract's troublesome resource-sharing cost algorithm was corrected, the MTFs and contractor needed to apply cost-benefit analysis to proposed resource sharing. The MTFs lacked data systems and analytic capability to easily do this.

At the time of the exit interviews in 1990—almost two years after the CRI contract began—solutions to the problems described above were being implemented, and CRI operations had become more efficient and were proceeding as planned. At most MTFs, the Commanders realized the benefits of the initiative and had developed fruitful working relations with CRI staff. Resource-sharing agreements were providing staff and resources to augment MTF capability and increase utilization.

Both civilian managed-care programs and the military health care system are complex operations. Merging them requires detailed planning, personnel with appropriate skills and training, the cooperation and support of all facets of the MHSS, education of those charged with carrying out the new program, and time for them to test and adjust the processes and procedures of the numerous components. Short cuts in any of these areas may prove counterproductive to intended goals.

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1. INTRODUCTION

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pays for much of the health care that dependents of active-duty personnel, military retirees and their dependents, and survivors of deceased service members get from civilian providers. In response to growing costs in CHAMPUS and dissatisfaction with the program on the part of its beneficiaries, the Department of Defense (DoD) proposed in 1987 a set of reforms based partly on civilian managed-care plans. The CHAMPUS Reform Initiative (CRI) makes reduced cost sharing available to those beneficiaries willing to restrict their physician choice to a specified provider network offering discounts for its services. CRI offers two new health plans as alternatives to the Standard CHAMPUS plan—a health maintenance organization (HMO) called CHAMPUS Prime and a preferred provider organization (PPO) called CHAMPUS Extra. Through these new plans, CRI improves coverage of preventive care and reduces paperwork for beneficiaries, introduces comprehensive utilization review, and promotes better coordination of civilian-provided care with care in military treatment facilities (MTFs).

Since CRI fundamentally changes the Military Health Service System (MHSS), Congress required a demonstration to test the initiative's feasibility and cost-effectiveness before nationwide implementation. The demonstration began in California and Hawaii in February 1988, and, following its planned five-year run,[1] Congress also mandated an independent evaluation of the CRI demonstration. RAND was asked to perform that evaluation.

The CRI contractor faced formidable challenges in implementing and operating the initiative. Before the demonstration began, the contractor needed to assemble networks of providers willing to discount fees in return for unpredictable increases in patient loads and attempt to secure those increases by marketing the Prime and Extra options to beneficiaries. The contractor also needed to train staff who would assist in directing beneficiaries to cost-effective treatment resources and needed to establish offices and communication services for that staff within the space-constrained MTFs. Data-processing systems were implemented that would support beneficiary enrollment in a discounted-fee option, cost-effective resource use, utilization management, and estimation of DoD payments to the contractor. To achieve these objectives, the systems supported automated extraction of information about a variety of factors from claims records. Almost all of this needed to be accomplished in a six-month period and on a scale sufficient to accommodate tens of thousands of beneficiaries within the first year of the demonstration. Once the demonstration began, the contractor needed to put in place measures to more efficiently utilize existing MTFs, measures whose development and realization required close cooperation with MTF commanders and their staffs.

The record of CRI's implementation and operations provides context helpful for understanding the results of the evaluation of CRI's cost and health outcomes and affords lessons for implementing similar reforms elsewhere. In this volume, we describe the implementation and first years of CRI operations, the period from February 1988 to December 1990. The de-

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[1]CRI continued in California and Hawaii after the demonstration ended and was expanded to some other areas where MTFs were being closed. DoD has also issued a request for proposals for Washington and Oregon.

scription includes the geographical setting of the demonstration, participating organizations, their interrelationships, and the procedures and structure established to run the demonstration. From numerous interviews with personnel from the organizations involved and review of pertinent documents, we identify achievements, problems encountered, and adjustments to correct those problems and thereby fulfill the demonstration's goals. We also draw lessons that are relevant to implementing managed health care elsewhere in the MHSS. While synthesis of the material from the interviews has required that we exercise judgment and draw inferences, we have not attempted a formal evaluation of the demonstration's implementation and operations relative to criteria derived from theory or the experience of others. Our discussions of problems and achievements, advantages and disadvantages, and lessons learned should thus be regarded as indicative rather than definitive.

The report is organized in seven sections. Following this introduction, we provide some background on the components of the MHSS and the problems leading to CRI, the purpose and features of CRI, and the evaluation itself and the context of the demonstration. In Sections 3 and 4, we describe those aspects of CRI's implementation that were largely independent of interaction with the MTFs. Section 3 deals with actions that needed to be taken before health care could be managed through CRI's provider networks, that is, provider networks needed to be established and their use promoted to the beneficiaries. Section 4 addresses issues associated with the provision of health care, i.e., reviewing utilization and processing claims. In Sections 5 and 6, we examine the role of the MTFs in CRI, in particular, measures taken to more fully utilize these existing facilities and to direct patients to the most cost-effective treatment sources. In the final section, we offer the lessons we think are to be learned from the two years of observing this demonstration.

2. BACKGROUND

MILITARY HEALTH SERVICE SYSTEM

The primary functions of the MHSS are medical support of U.S. combat forces during wartime and, in peacetime, maintenance of the health of active-duty personnel, their dependents and survivors, and military retirees and their dependents and survivors. The MHSS currently provides at least part of the health care for 9.2 million eligible persons, over 7 million of whom are retirees, dependents, and survivors. The system consists of military and civilian sources of care.

Military Treatment Facilities

The Army, Navy, and Air Force spent $6.3 billion in fiscal year (FY) 1992 to operate approximately 500 treatment facilities, including over 100 hospitals.[1] These facilities provide most of the medical care for active-duty persons and care on a space-available basis to all eligible non–active-duty persons.

Non–active-duty beneficiaries may use the MTFs for medical care free of charge if one is near enough, if it has space available,[2] and if they do not prefer to use other health care alternatives. Non–active-duty beneficiaries who live near MTFs receive most of their care from the MTFs. In the CRI areas, these beneficiaries obtain about two-thirds of their outpatient care from the MTFs; this percentage varies from 40 to 90 percent, depending on the location.

MTFs do more than just provide care to active-duty and non–active-duty persons. They also maintain a standby expansion system for providing medical care during war—a mission generating many separate activities within MTFs currently—and provide staff to support ongoing military activity (such as shipboard medical care). At many MTFs, there are further missions such as environmental and occupational health or aerospace and flight medicine, which are all related to current operations of the military.

The Civilian Component: CHAMPUS

Until 1956, MTFs were the only providers of DoD-funded health care to military dependents and retirees. That year, Congress enacted a program to improve military beneficiary health care by supplementing MTF capability with government-financed civilian health services. Civilian health service costs for dependents and survivors of active-duty personnel and retirees are shared through a health benefits payment program—the second MHSS component—CHAMPUS.

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[1]Goldberg, Matthew S., et al., *Cost Analysis of the Military Medical Care System: Data, Cost Functions, and Peacetime Care*, Institute for Defense Analysis, P-2938, 1994.

[2]In emergencies, however, MTFs turn no one away.

CHAMPUS is administered by the Secretary of Defense through the Office of the Assistant Secretary of Defense (Health Affairs).[3] CHAMPUS roughly parallels other public and major private health care plans. It covers its beneficiaries until they reach age 65 or are otherwise eligible for Medicare. There are over 6 million CHAMPUS beneficiaries. As in private plans, CHAMPUS participants generally pay part of their medical and hospital bills and often are required to fill out claim forms. There are limits to the amount participants pay from their own pockets during a single year to keep major illnesses from bankrupting families. CHAMPUS does not cover all medical procedures and does not necessarily reimburse patients for all expenses, but its benefits by current civilian standards are unusually generous. Table 1 gives the details of copayments, deductibles, and coverage of the Standard CHAMPUS plan.

Table 1

Benefits and Coverage for CRI Options

	Standard CHAMPUS	CHAMPUS Prime	CHAMPUS Extra
Annual deductible	Jr enlisted: $50 indiv./ $100 family. Others: $150 indiv./$300 family	None	Same as Standard
Physician services copayment			
Active-duty dependents	20% of CHAMPUS allowable	$5 per visit	15% of plan allowable
Retired and dependents	25% of CHAMPUS allowable	$5 per visit	20% of CHAMPUS allowable
Outpatient mental health copayment			
Active-duty dependents	20% of CHAMPUS allowable	$10 per individual visit $5 per group visit	15% of plan allowable
Retired and dependents	25% of CHAMPUS allowable	$10 per individual visit $5 for group visit	20% of plan allowable
Preventive services			
Active-duty dependents and retired and dependents	None except well baby care and routine eye exams	Routine physical exams, pap smears, and similar preventive care	Same as Standard
Hospitalization copayment			
Active-duty dependents	Greater of $25 or $8.05/day	Same as Standard	Same as Standard
Retired and dependents	Lesser of $210/day or 25% of charges	$75/day to $750 maximum per admission	Lesser of $125/day or 25% of charges
Prescription copayment			
Active-duty dependents	20% of CHAMPUS allowable	$4 copay up to 30-day supply	15% of plan allowable
Retired and dependents	25% of plan allowable	$5 copay up to 30-day supply	20% of plan allowable
Providers covered	Free to use virtually any provider	Must use network providers while enrolled	Must use network providers for particular episode of care; no enrollment
Paperwork required	Beneficiary often files own claim	No beneficiary claims filing	No beneficiary claims filing

NOTE: No Prime copayment for primary care or preventive services for dependents of sponsors with pay grades of E-4 and below.

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[3]During the period covered by this report, the cost of treating active-duty personnel in the private sector was borne by the Services (Army, Navy, Air Force). The Navy provided health care support for the Marine Corps. In FY 1992, however, the budget was consolidated under the Assistant Secretary of Defense for Health Affairs.

Beneficiaries' freedom of provider choice varies depending on whether the care is inpatient or outpatient and on where the beneficiary lives. CHAMPUS eligibles are free to choose most outpatient care from civilian providers whenever they wish.[4] For CHAMPUS to cover the cost of inpatient care, CHAMPUS eligibles living within the "catchment area" (i.e., within 40 miles) of a military hospital must check there first to see if it can provide the inpatient treatment. If the military hospital cannot provide inpatient care, a written nonavailability statement (NAS) is issued by the military facility to permit use of CHAMPUS at civilian hospitals. For those who live outside a military hospital's catchment area (about one-quarter of all CHAMPUS beneficiaries), prior authorization is not required for inpatient care.[5]

THE CHAMPUS REFORM INITIATIVE

Over recent years, increased usage and sharply rising medical costs have caused marked increases in CHAMPUS and MTF costs. The most visible component of medical costs is Program 8 of the DoD budget, which includes the operations and maintenance costs for direct care (including the MTFs), CHAMPUS, and other military medical activities. Figure 1 shows that the growth in these costs was 11.5 percent annually from 1981 until 1987, the year before CRI was implemented. The rate of increase in CHAMPUS was even higher—15 percent. Containing these increases, which reflected the general rise in health care costs in the nation, was a major CRI goal.
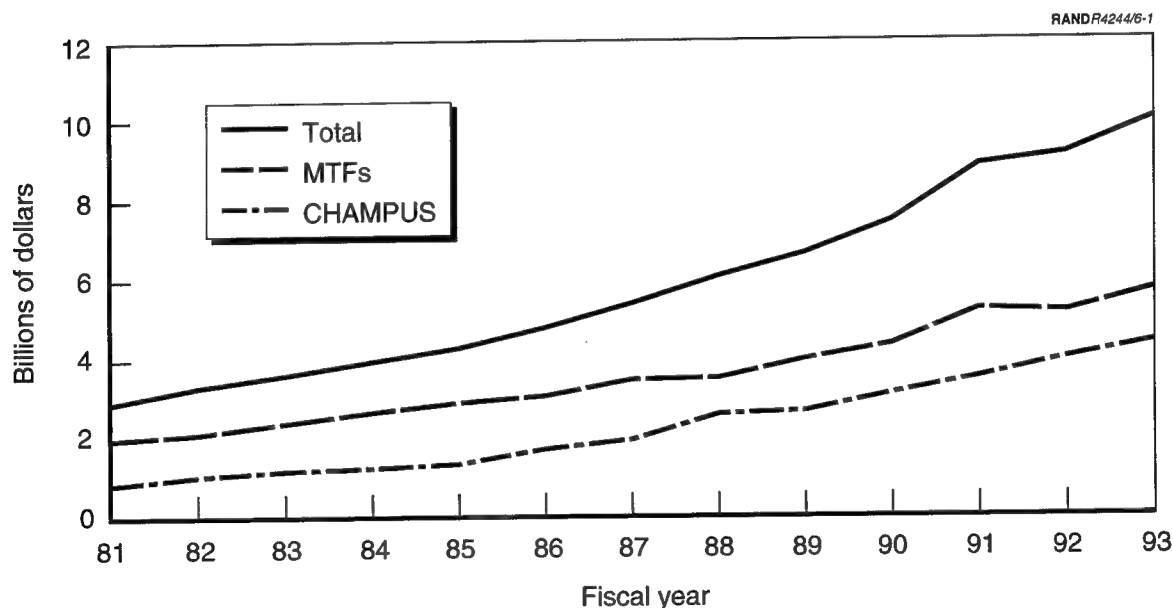
Figure 1—Cost of DoD Medical Activities (Program 8), FYs 1986–1991

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[4]CHAMPUS will cover civilian provider fees for ambulatory or same-day surgery and certain expensive diagnostic tests only if these services are unavailable at the MTF in the beneficiary's catchment area and written authorization is provided by the MTF.

[5]The Services are considering increasing the use of precertification. The FY92–93 Defense Authorization Act provides for expanded catchment areas for highly specialized care, such as organ transplants.

CRI had other goals as well. Military dependent and retiree beneficiaries have increasingly complained about the military health system. They cited difficulty in getting MTF appointments, the high deductible and copayments required by CHAMPUS, difficulty in finding doctors who would accept the fees paid by CHAMPUS, and having to file claims. In 1987, in an attempt to contain the cost of CHAMPUS both for the government and its beneficiaries and to promote beneficiary access to care, DoD proposed the CHAMPUS Reform Initiative. CRI was endorsed by Congress in the 1987 National Defense Authorization Act, which specified three key parameters:

1. The demonstration project was to begin not later than September 30, 1988.
2. The scope of the demonstration was restricted to not more than one-third of covered beneficiaries nationwide. California and Hawaii, the CRI area, had approximately 835,000 beneficiaries in 1988. This represented 16 percent of the 5.3 million CHAMPUS beneficiaries nationwide.
3. A health care enrollment system was to be implemented under the demonstration.

The demonstration's purpose was to determine if managed health care can significantly improve upon CHAMPUS by increasing access to care while containing costs. Major policy objectives of CRI included (1) containing CHAMPUS costs by bringing innovative managed health care techniques to the CHAMPUS delivery system, (2) maintaining the quality of the medical care CHAMPUS beneficiaries receive, (3) correcting the problem of poor access to care many beneficiaries experience, and (4) coordinating delivery of health care between the military and civilian sectors.

Demonstration Areas and Contractors

The original plan was for a national demonstration that would encompass two states in three of the six CHAMPUS regions: California and Hawaii in the Southwestern Region; North Carolina and South Carolina in the Mid-Atlantic Region; and Florida and Georgia in the Southeastern Region. Three contracts were envisaged to implement the demonstration. As proposed, each contractor would operate a managed-care CHAMPUS program and assume the financial risk within a two-state area. These six test states were selected because they were areas where military hospitals were overcrowded, CHAMPUS costs and volume were very high, and beneficiaries needed the most help in paying their share of services provided by civilians.

Proposals to conduct a demonstration were undertaken by a consortium of insurance companies and managed-care corporations for each of the three regions. The DoD design of the health care plan required that the bulk of all care continue to be provided in military hospitals and clinics and that participation in the managed-care plans (Prime and Extra) remain voluntary. DoD's demanding design and performance requirements coupled with a fixed-price contract caused the Southeastern and Mid-Atlantic Regions' consortia to withdraw their proposals. An added consideration for the Southeastern Region's consortium was the adoption of prospective payment for CHAMPUS hospital services, which seriously limited the

contractor's ability to negotiate discounts.[6] Only the Western Region's consortium concluded that the risks were manageable, and, thus, the only proposal was for the demonstration in California and Hawaii. The final contract remained fixed price but underwent an intensive period of negotiation focused on lowering the risk to the contractor through complex formulas that provided for sharing both potential profits and losses with DoD.

In February 1988, DoD awarded a $3 billion contract to a group of companies headed by Foundation Health Corporation (FHC) of Sacramento, California. The contract covered conducting the CRI demonstration in California and Hawaii over the period 1988–1993. Members of this group included the following:

- FHC, headquartered in Sacramento, California.[7]
- Foundation Health Plan (called "Foundation" in this report)—a subsidiary of FHC.[8] Foundation operates a series of independent practice associations (IPAs[9]) primarily in the western states. FHC subcontracted with Foundation to manage the CHAMPUS Program for Northern California.
- Partners Health Plan (called "Partners" here), which develops and manages HMOs, PPOs,[10] and other health care products. Partners was the subcontractor managing the CHAMPUS program for Southern California.[11]
- Queen's Health Care Plan ("Queens") is a nonprofit corporation owned by Queen's Medical Center and other providers in Hawaii and was the subcontractor for that state.
- Blue Cross of Washington and Alaska (BCWA) was the subcontract fiscal intermediary to process claims for CHAMPUS beneficiaries who stayed with Standard CHAMPUS. In early 1989, Electronic Data Systems was chosen as the subcontractor to handle claims for beneficiaries in Prime or Extra.

Features

CRI was designed with five main features to accomplish its goals: (1) management of CHAMPUS by a civilian contractor who shares in the risk associated with CHAMPUS utilization, (2) establishment of preferred provider networks and managed care for beneficiaries under options known as Prime and Extra, (3) augmentation of MTFs with civilian providers and health care resources that would improve their capability to deliver care, (4) the implementation of a function called a Health Care Finder (HCF) to assist patients in finding an appropriate and cost-effective provider for their medical needs, and (5) utilization review for care provided through the network and all mental health care.

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[6]Under prospective payment, hospital services are prepaid according to a schedule of allowable payments for each type of diagnosis.

[7]In 1990, FHC was reorganized and subsequently transferred its CRI contract to its newly created, wholly owned subsidiary, Foundation Health Federal Services, Inc.

[8]In 1989, Foundation Health Plan became Foundation Health, A California Health Plan.

[9]An IPA is a type of health maintenance organization that contracts with physicians in independent practice settings.

[10]A PPO is a network of medical care providers who discount services to customers (e.g., employers) who can direct a large number of patients their way.

[11]In late 1991, Partners Health Plan was renamed Aetna Health Plans.

Risk Sharing. The CRI contract provides for a prospective payment for each option period; the contract defined three six-month periods and three one-year periods of program operation. DoD and the contractor share the risk for differences between the prospective payment and actual costs. However, the prospective payment is regularly adjusted for unanticipated changes in beneficiary population and non-CRI trends in utilization. The financial provisions in the CRI contract are complex, and, as we describe below regarding resource sharing, they caused some unexpected problems that caused the contract to be amended slightly. The amendment did not alter the basic methods used to reimburse the contractor.

CRI's prospective payment covers all costs other than for MTF services. It covers CHAMPUS health care costs and the contractor's administrative costs and allows for a profit of 6.33 percent of those costs. The original prospective amount for health care costs was based on data on the population eligible for CHAMPUS and their CHAMPUS health care utilization prior to CRI. It was also based on the assumption that there would be some cost savings for those beneficiaries expected to participate in Prime and Extra. In arriving at the bid price, health care costs were estimated by

- type of service: inpatient services (paid prospectively by diagnosis-related group [DRG]), other inpatient services, and outpatient services
- type of plan: managed care (Prime or Extra) or Standard CHAMPUS
- category of beneficiary: active-duty dependents or retirees and their dependents.

The price set out in the original contract for each option period is adjusted after the end of the period and again after later periods until the data are complete. The bid price is adjusted for unexpected changes in several factors. The bid price is adjusted in the same direction as (1) the change in eligible population (by beneficiary category), (2) total MTF and CHAMPUS utilization (by type of service) in non-CRI areas, and (3) the per-unit price of service cost. The bid price is adjusted in the opposite direction as the change in MTF utilization (by type of service) in CRI areas because, if MTF utilization increases, there should be less CHAMPUS utilization. In general, per-unit cost adjustment is restricted to the increase in the appropriate component of the Consumer Price Index for the managed-care programs and to increases in non-CRI CHAMPUS unit costs for the Standard program. Forty-six percent of administrative costs are assumed to vary with utilization. That fraction is adjusted in the same manner as health care costs; the other 54 percent is not adjusted. The profit is also adjusted to remain at 6.33 percent.

For the first six months of CRI operations, the adjusted bid price estimated in the original contract was $237 million. The adjusted price for the last year of the original contract was $680 million, for an average annual cost increase of 8.4 percent.

DoD and the contractor share any gains or losses in the program. To determine whether there was a gain or loss, the actual health care costs incurred in each option period are compared with the (adjusted) health care costs in the bid price. For example, if population and MTF utilization hold constant, a gain would be realized if (though not only if) all of the following were true:

- Per-unit cost increased more slowly than health care prices generally (for Prime and/or Extra)

- Per-unit cost increased more slowly than that in non-CRI areas (for Standard CHAMPUS)
- CHAMPUS utilization increased more slowly than it did in non-CRI areas.

A gain *could* result if *any* of the above were true, provided that faster increases in the other factors did not compensate for it. Note that, because rewards (and losses) are based on differences in cost or utilization increases *in each period,* the savings from a given period's efficiencies are realized only once.

The risk-sharing formula allocated 25 percent of the savings to the contractor and 75 percent to DoD. Small losses are absorbed by the contractor. Moderate losses are shared, with the contractor's share increasing after the first year of the demonstration. DoD absorbs all losses over 20 percent of the adjusted bid price estimate. The contractor's cumulative loss over the course of the demonstration is also capped at less than 1 percent of one year's bid price.

Because of the adjustments, CRI is not truly a capitated contract, i.e., one that has a fixed price per beneficiary and thus offers particularly powerful incentives to control costs. Nevertheless, the contract does provide, through its risk-sharing provisions, many of the same incentives that a more conventional capitation contract would. Our interviews with contractor personnel, especially concerning decisions regarding enrollment targeting and resource sharing, indicate that those incentives strongly influenced the contractor's operation of CRI.

New Options for Beneficiaries. CRI provides two voluntary options in addition to the Standard CHAMPUS program offered in other states and in the demonstration area before CRI. Copayments, deductions, and other features of the three options are summarized in Table 1. Both CRI plans are based on a network of physicians who agree to discount their fees and adhere to utilization management procedures, including a review of their practice patterns.

The first option, called CHAMPUS Prime, is an enrollment plan similar to that of an HMO, but based on the IPA model. To use the Prime plan, beneficiaries relinquish some freedom in their choice of medical providers in that they use only military providers or the preestablished network of civilian providers. In Standard CHAMPUS, in contrast, choice is restricted only by a requirement for an MTF nonavailability statement for certain services. At the outset of the demonstration, Prime was not available in all catchment areas (see Table 2).

When enrolling in Prime, the beneficiary must designate either the MTF or a civilian network physician as their primary care provider.[12] (Some MTFs chose not to act in this capacity; see Table 2.) Referrals to civilian specialists must come from the primary care provider. Access to the MTF generally is unrestricted.[13] It was thought that this system would help contain costs in four ways. First, patients would be restricted from self-referring

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[12]Primary-care providers are general practitioners, family practitioners, obstetricians/gynecologists (ob/gyn), pediatricians, and internists.

[13]Access to MTF specialists may require a primary-care physician's referral, depending on the MTF's rules for access.

Table 2

Locations of CHAMPUS Prime, Extra, and Health Care Finder Services (July 1991)

Catchment Area	CHAMPUS Prime	CHAMPUS Extra	Health Care Finder	Designated PCP[a]	PRIMUS/ NAVCARE[b]
Foundation Health Plan (Foundation Health, Inc)					
Travis AFB	8/1/88	8/1/88	Yes	Yes	No
Naval—Mare Island[c]	8/1/88	8/1/88	No	Yes	No
Vandenberg AFB	12/1/91	8/1/88	Yes	Yes	No
Castle AFB	8/1/88	8/1/88	Yes	No	No
Mather AFB	8/1/88	8/1/88	Yes	Yes	Yes
McClellan AFB[c]	8/1/88	8/1/88	Yes	Yes	No
Beale AFB	8/1/88	8/1/88	Yes	Yes	No
Letterman	3/1/89	8/1/88	Yes	Yes	No
Fort Ord	3/1/89	8/1/88	Yes	Yes	Yes
Naval—Oakland	3/1/89	8/1/88	Yes	Yes	Yes
Naval—Lemoore	12/1/91	8/1/88	Yes	No	No
Naval—Port Hueneme[c]	12/1/91	8/1/88	Yes	Yes	No
Partners Health Care Plan					
March AFB	8/1/88	8/1/88	Yes	Yes	Yes
George AFB	8/1/88	8/1/88	Yes	No	No
Edwards AFB	12/1/91	11/1/88	Yes	Yes	No
Norton AFB[c]	8/1/88	8/1/88	Yes	Yes	No
Fort Irwin	12/1/91	8/1/88	Yes	Yes	No
Naval—San Diego	8/1/88	8/1/88	Yes	Yes	No
Coronado[c]	8/1/88	8/1/88	Yes	Yes	No
Miramar[c]	8/1/88	8/1/88	Yes	Yes	No
Station—San Diego[c]	8/1/88	8/1/88	Yes	Yes	No
Naval—Long Beach	8/1/88	8/1/88	Yes	Yes	Yes
Los Angeles AFB[c]	8/1/88	8/1/88	Yes	No	No
Station—Long Beach[c]	8/1/88	8/1/88	Yes	Yes	Yes
Marines—El Toro[c]	8/1/88	8/1/88	Yes	Yes	No
Naval—Camp Pendleton	8/1/88	8/1/88	Yes	Yes	Yes
Twenty-Nine Palms	12/1/91	8/1/88	Yes	No	No
Marines—Barstow[c]	12/1/91	8/1/88	Yes	Yes	No
Queen's Health Care Plan					
Tripler—Honolulu	8/1/88	8/1/88	Yes	Yes	No

[a]Primary-care provider, i.e., whether MTF was willing to be so designated by beneficiaries.

[b]Clinics extending MTFs' primary-care capacity and run by contractors other than that for CRI; no direct cost to latter for care provided there (but bid price adjusted downward for increased utilization, as with MTFs).

[c]Clinic.

for expensive duplicative and unnecessary services. Second, as MTFs still cost beneficiaries nothing, the latter would have an incentive to use the military facilities, which were thought to provide care less expensively than civilian providers. Third, at least for high-cost procedures, the CRI contractor also has a financial incentive to maximize MTF use, because the contractor would have to pay more for civilian-provided health care services for CHAMPUS beneficiaries than would be deducted from his payment for increased MTF-provided services.[14] Fourth, if care is unavailable at the MTF, patients are sent to discounting network providers.

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[14]In the case of procedures for which CHAMPUS costs per unit of utilization (bed day, visit) were relatively low, the contractor might not have a financial incentive to maximize MTF use. As discussed above, the contract price was adjusted downward if MTF utilization increased.

The reduced freedom of choice for beneficiaries is offset by presumably better access to care, additional benefits (e.g., periodic checkups and immunizations), reduced cost, and less paperwork. A membership card in most cases replaces claims forms. Claims forms are necessary only if the beneficiary needs a nonnetwork physician, e.g., for an emergency, or a specialist not available in the network. Beneficiary costs in the Prime plan include a nominal copayment—usually $5 per doctor visit; in Standard CHAMPUS, costs are 20–25 percent of total physician fees after satisfying a yearly deductible.[15]

The second option is known as CHAMPUS Extra and is available in all catchment areas. In this option, the Prime network operates as a point-of-service PPO. To take advantage of this option, beneficiaries do not need to enroll. Instead, they remain in Standard CHAMPUS and may or may not use the Prime network for medical care. They do not receive the additional coverage and the very low cost sharing of the Prime option, but their copayment percentages are somewhat reduced if they use the network providers. These providers offer discounted fees that result in still lower copayments for the beneficiaries. Also, Extra providers cannot bill patients for more than CHAMPUS will cover. As in Prime, there are no claims forms associated with using these physicians.

Other Features. Three other major innovative features of CRI are resource sharing, an HCF, and utilization review. Their purpose is to more fully utilize the MTFs for beneficiary care and improve the appropriateness of civilian care, thereby reducing CHAMPUS costs. Resource sharing was designed to improve the health care delivery capability of the MTF. Resource-sharing agreements allow the plan subcontractors to purchase additional resources for the MTF. In situations where lack of such resources keeps substantial capabilities from coming into play, their purchase could be highly efficient in terms of the care made available per dollar spent. An HCF, stationed at the CHAMPUS Service Center at each MTF and several major clinics, ensures that the MTF and network are utilized to the maximum extent possible by referring beneficiaries to the MTF or appropriate network civilian providers when care is unavailable at the MTF. This referral assistance is not available to beneficiaries who do not use network providers. Utilization review entails a prospective review of the need for medical care, a second medical opinion on the need for and level of care, review of a patient's records while care is being given, case management of long-term care, and retrospective review of the claims submitted after the care has been given.

THE EVALUATION

Because of the relation between aspects of the implementation and the findings of the evaluation of cost and health outcomes, some background on the evaluation itself is presented here. The demonstration area (California and Hawaii) contains 18 hospitals and several major military clinics (see Table 2). To conduct this evaluation, RAND selected 10 military hospitals and one large clinic for intensive study. The 11 demonstration MTFs selected for the evaluation represent all branches of Service and military hospitals of different sizes. They also represent several geographic areas within California and include the one MTF—Tripler, a medical center—served by the Hawaii CRI subcontractor, Queen's Health Care

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[15]The deductible was $50 for an individual and $100 for a family until 1991, when it was raised to $150 and $300, respectively, for all but junior enlisted families.

Plan. Each of these MTFs was matched with a similar "control" MTF from outside the CRI demonstration area. The latter are listed in Table 3.[16]

The purpose of matching demonstration and control MTFs was not to compare these medical facilities on a one-to-one basis—that is, a demonstration site to its matching control site—but rather to look at the experiences of the control sites as a whole in caring for their beneficiary population over and against the experiences of the demonstration sites and to determine how much of the difference could be attributed to CRI. The results of these assessments are reported elsewhere in this series of reports. This descriptive overview and the interviews conducted to support it were designed to learn about (1) circumstances—especially those unrelated to CRI—within each group of sites that might affect our assessment of CRI outcomes and (2) how the control sites used partnerships and other new programs during the evaluation period to alter their health care service delivery capability.

INFORMATION SOURCES FOR THIS REPORT

Information relating to implementation issues was obtained from in-depth structured interviews with the key staff at the 11 MTFs in the demonstration area.[17] The hospitals and clinics at the bases were visited shortly after CRI operations began and approximately two years later. We also conducted one set of interviews during the demonstration period at two large MTFs not chosen as evaluation sites—Letterman Army Medical Center and Naval Hospital Oakland. Interviews were held with the MTF commander; administrator; medical director; head of nursing; heads of the major ancillary departments—radiology, laboratory,

Table 3

Military Treatment Facilities Selected for Evaluation

Demonstration	Control (State)
David Grant Medical Center, Travis AFB	USAF Medical Center, Keesler AFB (Miss.)
814th (9th) Strategic Hospital, Beale AFB	USAF Hospital, Dover AFB (Del.)
22nd Strategic Hospital, March AFB	Robert Thompson Strategic Hospital, Carswell AFB (Tex.)
USAF Hospital, Mather AFB	31st Medical Group, Homestead AFB (Fla.)
1st Strategic Hospital, Vandenberg AFB	363rd Medical Group, Shaw AFB (S.C.)
Tripler Army Medical Center	Madigan Army Medical Center, Fort Lewis (Wash.)
Silas B. Hayes Community Hospital, Fort Ord	Darnall Army Hospital, Fort Hood (Tex.)
Naval Hospital San Diego	Naval Hospital Portsmouth (Va.)
Naval Hospital Long Beach	Naval Hospital Orlando (Fla.)
Naval Hospital Camp Pendleton	Naval Hospital Charleston (S.C.)
Naval Clinic Port Hueneme	Naval Medical Clinic Quantico (Va.)

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[16]For more information on the selection of the demonstration and control sites, see Hosek, Susan D., Dana P. Goldman, Lloyd S. Dixon, and Elizabeth M. Sloss, *Evaluation of the CHAMPUS Reform Initiative: Volume 3, Health Care Utilization and Costs*, Santa Monica, Calif.: RAND, R-4244/3-HA, 1993.

[17]We also interviewed staff at the 11 corresponding control sites. The principal purpose of these interviews was to learn whether aspects of MTF and CHAMPUS operations at those sites might influence the interpretation of the results of the evaluation reported in the companion volumes. Such potential influences are discussed in those volumes.

and pharmacy; the clinical administrator; the head of Resource Management and/or comptroller; the head of Patient Administration; the Health Benefits Advisor; and two or three physicians.[18]

Several days were spent with CRI staff at the headquarters of the contractor and each of the subcontractors. At the demonstration sites, we interviewed the subcontractors' service area and HCF managers and other relevant CRI staff based at the MTF.

Information from the interviews at the sites covered by the evaluation was supplemented by data on the entire demonstration area drawn from several other sources. Reports, manuals, and documents were provided by the contractor (FHC), the subcontractors (Partners, Queens, and Foundation), and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD [HA]).

GENERALIZING THE LESSONS LEARNED

The lessons we draw from the interviews we conducted can be applied with caution only to the introduction of managed care in the military program in other parts of the country. That is because, in many respects, the demonstration area was atypical of the rest of the continental United States.[19] For example,

- The demonstration area was more medically served than the other states. California and Hawaii had about 10 percent more nonfederal hospitals and 17 percent more physicians per capita than other states.
- CHAMPUS inpatient-day costs were 17 percent higher in the demonstration area, though outpatient costs were much the same.
- In CHAMPUS, inpatient utilization was lower in the demonstration area (by 10 percent for total days and by 37 percent for admissions), while outpatient use was about 25 percent higher. This pattern could be related to the historical emphasis on managed care in the demonstration area. Thirty-one percent of the demonstration area's total population was in HMOs, compared with 12 percent elsewhere.
- More resources were available to MTFs in the demonstration area: A higher percentage of MTF beds (71 percent versus 50 percent elsewhere) were in medical centers, and there were more uniformed caregivers (1.96 per 1,000 beneficiaries compared with 1.64). Also, the 11 demonstration sites had newer facilities on the average than the control sites in other states.

Health care providers may have less incentive to join managed-care networks in areas where the competition for patients is weaker and where fees are lower to begin with. It may also be more difficult to institute managed care in areas with less experience with such arrangements. And MTFs in other parts of the country may not be in as good a position to expand their delivery of care.

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[18]The appendix contains a list of the questions asked during the interviews. Each interviewee was asked the subset of the questions relevant to his or her responsibilities at the MTF and/or in CRI.

[19]The control sites, however, were more similar to the CRI areas.

3. ESTABLISHING THE CRI PLAN OPTIONS

Under the terms of the contract, the consortium—FHC, the subcontractors (Queens, Foundation, and Partners—the "Plans"), and the fiscal intermediary (Blue Cross of Washington/Alaska)—had six months to implement the delivery of health care services to all eligible CHAMPUS beneficiaries in California and Hawaii. The period—February 1988 to the beginning of operations on August 1, 1988—was devoted to creating and organizing the components necessary to operate a managed health care system in conjunction with military installations in California and Hawaii. Some of these components, notably the provider network and the claims-processing apparatus, needed substantial continuous attention throughout the period of operations that followed. In this section, we describe the establishment of the provider networks and the marketing and enrollment efforts undertaken to get enough beneficiaries to support and take advantage of those networks.

It was necessary at the outset to take measures to ensure that developing a provider network, marketing the plan options, enrolling beneficiaries, and all other activities would run along the same lines in all CRI areas. Eleven task forces staffed by each Plan and FHC were formed in March 1988 to ensure a uniform health care program for the California-Hawaii CHAMPUS population and to develop policies and procedures accordingly and communicate them to CRI staff, MTFs, and CHAMPUS beneficiaries. Each task force was concerned with the development of training programs, reports, protocols, guidelines, and manuals in a different subject area. The task forces continued into the operational phase of CRI as standing committees to address problems that still required resolution.

FHC also issued an enrollment and beneficiary services newsletter to keep those interested informed on enrollment statistics, policy interpretation, claims information, and Standard CHAMPUS policy issues.

ESTABLISHING AND MAINTAINING PROVIDER NETWORKS

An essential element in a managed-care operation such as CRI is assembling a group of physicians, hospitals, and other providers who agree to treat patients for a reduced fee[1] and to follow procedures that contribute to quality of care, cost-effectiveness, and beneficiary satisfaction. Those procedures included permitting review of their credentials and their medical practice patterns and submitting claims on behalf of CHAMPUS beneficiaries using their services.[2] In return for the reduced fee and the adherence to cost-effective medical management protocols, these physicians and facilities expect to treat a high percentage of the patients who are participating in the managed-care program.

The CRI contract stipulated that FHC and the Plans would establish comprehensive networks of providers in areas where CHAMPUS Prime would be offered; a follow-up white paper issued by OASD (HA) specified that Prime was to be offered in 12 of the 18 catchment areas in California and Hawaii. Nine of the catchment areas offered the Prime plan in August

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[1]Fee reductions were not required for specialty providers in short supply in a given area.

[2]It was also required that network providers be fluent in English.

1988. Three more sites were added by the spring of 1989 for a total of 12. (See Table 2 in Section 2; eventually, all catchment areas offered Prime.) The contract also allowed the establishment of preferred provider networks in areas where Prime was not offered. (Networks in such areas would function under the Extra option only.)

Incentives for using preferred providers were to be uniform throughout the demonstration area where preferred provider benefits are offered. That is, the number of preferred providers and their geographical distribution relative to the beneficiary population—in short, their accessibility—could not vary significantly from one catchment area to another.[3] Specifically, for example, providers had to be distributed so that most beneficiaries can reach them within 30 minutes' travel time and in numbers and specialty mix that would satisfy enrollees' demand for the various types and levels of care.

Although Prime enrollees were restricted to using Prime network or MTF providers, the restrictions could not result in beneficiaries receiving inadequate care, inadequate emergency services, or inadequate special services. If the network providers could not supply care needed by a Prime enrollee, the Plans had to authorize nonnetwork care.

In the remainder of this subsection, we describe how the Plans went about satisfying the contract's network requirements and how successful their efforts were. We also briefly discuss the establishment of discount rates and the education of network providers regarding responsibilities under CRI.

Network Development Strategies

In designing their networks, the Plans used different strategies according to geographic location, their existing contractual relationships with providers, numbers of CHAMPUS eligibles in an area, and the regional competitive environment of the provider marketplace. In general, they aimed for enough providers to meet beneficiary demand. However, they tried to keep the number low enough so that preferred providers could increase their volume of CHAMPUS patients and maintain a mix of CHAMPUS and non-CHAMPUS patients. The formula Partners used to determine the optimal number of providers for a catchment area assumed that 25 percent of CHAMPUS-eligibles were users and that 10 percent of those users would enroll in Prime and 40 percent would use the Extra option. Foundation applied Knox-Keene[4] standards to its network development—one primary care physician for every 2,000 beneficiaries. In some rural areas where Knox-Keene standards could not be met, contracts were made with as many providers as were available in that area.

In choosing providers for the network, the Plans relied largely on their area knowledge and network development expertise. They built on their own preexisting commercial networks and used their commercial network administrative staffs to support CRI. For example, since Partners was formed as a joint venture involving Voluntary Hospitals of America (VHA), their strategy was to recruit VHA hospitals and their medical staffs. To help fill out their networks, the Plans used claims data from BCWA passed through FHC to identify the highest 10 percent of providers filing CHAMPUS claims. In late 1989, the networks picked up

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[3]Again, exceptions were made for specialties in short supply.

[4]The California Knox-Keene Health Care Services Plan Act of 1975 (California Administrative Code Title 10) specifies providers' access and quality licensing requirements.

some additional doctors who had been in partnership arrangements with MTFs but who were induced to join by the attractive no-claims feature of CRI resource sharing.[5] Provider recruitment has continued over the course of the demonstration since new providers are always needed to replace those who drop out.

The Plans used the MTFs very seldom for advice in obtaining physicians and facilities for their networks. Some MTF personnel criticized what they considered the mediocre quality of some network hospitals. Even in the operational period, they continued to express concerns that some "premier" hospitals—prestigious institutions that the MTFs particularly wanted in the networks—were not in the networks. However, this issue appears to have abated over the course of the demonstration: It was not brought up by staff interviewed in the second interview in 1990. We suspect that concerns diminished as some premier hospitals eventually joined and as it became apparent that beneficiaries were satisfied with quality of care at the other network hospitals.

To credential their network providers, the Plans used an eight-page application based on DoD specifications. State license and Medical Board status were verified; malpractice experience and adverse claims histories were investigated.

Problems in Network Development

Network development was hampered by lack of information on providers, miscommunication, the reluctance of some providers to discount, a change in fiscal intermediaries, and problems in processing claims. Predemonstration data from the pre-CRI fiscal intermediary were unavailable. Limited information on patient and provider utilization was available, but detailed data on practice patterns and volume of CHAMPUS patients were scarce throughout the evaluation time period because claims processing problems (discussed below) prevented information from reaching the Plans. Without the information on providers available in the claims data, provider selection beyond the Plans' existing networks had to be based on reputation and willingness to discount fees.

Communication problems took various forms. One group of providers assumed the CRI HCF would work directly for them to obtain patients. When they were informed this was not the case, they refused to participate in CRI.[6] Confusion resulted at Partners when the assumption was made that a passive response to a letter sent out to its commercial network meant those providers would join the CRI network. These commercial network physicians assumed they would see patients at Standard CHAMPUS rates, with no discounts. When this proved to be otherwise, many to whom Prime enrollees had been assigned withdrew. Instances of miscommunication regarding providers' responsibilities led to frustration among network practitioners and may have contributed to withdrawals (see "Education of Providers" below).

Queens experienced a slight erosion of their network when they tried to incorporate their established providers into CRI. Some of these physicians would not accept the lower fee schedule associated with Prime and Extra. Over the next two years of CRI, almost one-half of the providers who left the Queens network did so for reasons of disaffection with some aspect of

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[5]Partnerships and resource sharing are explained in Section 5.

[6]Their withdrawal confused beneficiaries who had been given the names of these physicians as their primary caregivers.

CRI, mostly with claims processing. (But Queens was able to replace those who left; see "Adequacy of Network" below.)

It was difficult to establish networks sufficient to support the Prime program in remote areas because of the lack of physician specialists who would agree to discount their fees below the Standard CHAMPUS allowable. Indeed, in some medically underserved areas, physicians decline to accept even Standard CHAMPUS assignment.

Additional problems arose because the CHAMPUS program also changed fiscal intermediaries (FIs) for California and Hawaii. Standard CHAMPUS rules require providers to recertify with a new FI regarding their eligibility to treat CHAMPUS beneficiaries and file claims for payment. Providers were either not adequately notified of the need to recertify or, if they were, failed to do so. The recertification process often takes some effort to complete, and this requirement added to the complexity of network development during the short implementation period.

Finally, as discussed in Section 4, computer problems caused claims processing to back up and virtually stop for Prime and Extra. Providers began receiving unitemized estimated payments (70 percent of billed charges) for their services. This created large accounting problems for them since it was impossible to apply the estimated payments to individual patients' accounts. As a result, much time-consuming, costly effort had to be expended to keep providers in the CRI network, and fewer resources were available for educating providers.

Adequacy of Network

Despite the difficulties, the Plans were successful in assembling provider networks in all catchment areas (Table 4 shows the size of the networks in 1992). One year after the program began, the CRI networks included 113 hospitals and almost 9,000 physicians and ancillary professionals—up significantly from the start of operations in August 1988. As Table 4 indicates, the ratio of eligible beneficiaries to network providers varies by a considerable amount across catchment areas. Some of the variation appears to reflect the size of the Plans' preexisting networks. However, some areas required only a small network because the MTF provides most of the beneficiaries' care.

Success varied by area at first. Before CRI, Foundation had a large commercial network in the Sacramento area. At the start of operations, some areas in Northern California—Grass Valley and Nevada and Butte Counties, and the Coastal Monterey area—were deficient in network primary care providers, and there were other areas where specialty coverage was inadequate. By June 1989, Foundation had 50 hospitals and 4,926 physicians in the Northern California network; over 90 percent of the network primary care providers were accepting new patients. Premier hospitals eventually joined but often with smaller discounts than other hospitals accepted.

Partners had commercial networks in Riverside, Long Beach, Orange, and Los Angeles Counties, but not in San Diego County. That, and the fact that San Diego County had few PPOs and HMOs, made network development more difficult there. Given the short implementation period, Partners subcontracted with Behavioral Health Resources and Vista Hill for mental health providers in some areas. These subcontracts were in effect for about two years but were replaced with Partners' own providers in 1990.

Table 4

CRI Network

| Catchment Area | CHAMPUS Pop.[a] | No. of Network Providers[b] | |
		Hospitals[c]	Practitioners
David Grant MC	38,004	11(10/1)	447
Mather AFB	51,060	19(13/6)	1,496
Beale AFB	13,212	4	150
Letterman Army MC	20,033	14(12/2)	1,067
Ft. Ord	39,161	0	132
Naval Hospital Oakland	69,826	15(12/3)	733
March AFB	48,954	16	1,159
George AFB and Ft. Irwin	16,679	3	120
Naval Hosp. San Diego	172,261	12(9/3)	708
Naval Hosp. Long Beach	89,393	32(29/3)	2,741
Camp Pendleton	59,325	2(1/1)	191
Tripler Army MC	81,385	11(10/1)	406
Vandenberg AFB[d]	13,585	2	93
Castle AFB[d]	17,835	8(7/1)	377
Naval Hospital Lemoore[d]	16,310	14(11/3)	240
Port Hueneme[d]	e	6(5/1)	368
Edwards AFB[d]	12,987	2	100
Twenty-Nine Palms[d]	9,876	3	104

[a]Defense Management Information Service, 1990.

[b]CHAMPUS Reform Initiative, Network Health Care Providers by MTF Catchment Area, FHC Report, April 5, 1992.

[c]For pairs of numbers in parentheses, the first is the number of medical/surgical hospitals and the second is for mental health hospitals.

[d]CHAMPUS Prime became available December 1, 1991.

[e]RAND estimate; not an MTF, so no officially recognized catchment area (included here because it is one of the demonstration sites evaluated).

Gaps in hospital coverage that existed from the beginning of operations persisted through the period of observation. The northern area of San Diego County still lacked a network obstetric hospital in the summer of 1990. Acquiring providers for desert areas was especially difficult for Partners; for example, the desert town of Barstow was deficient in ob/gyns. Nevertheless, at the end of the first year of operations, Partners had 55 hospitals and over 4,450 providers in its network—an increase of 41 percent in providers and 77 percent in hospitals from August 1988. Partners reported that interest in network membership continued strong even after several years.

At the beginning of CRI, Queens had 75 percent of the required providers—including those in the high-volume specialties—in an established network of 400 physicians and seven hospitals. Queens utilized this existing commercial network and recruited other physicians, ancillary support, and hospitals to provide coverage for Oahu's neighbor islands, primarily Hawaii and Kauai.

By 1990, the Queens network contained nearly 500 physicians and 13 facilities. Primary care was available on all of the Hawaiian Islands with beneficiaries. A concentrated effort was under way to fill gaps in specialty and ancillary areas. The success of Queens at maintaining and even expanding the network was impressive because the state of Hawaii has little medical care competition. Kaiser, the largest HMO, covers about 20 percent of the civilian population, but there are few other HMOs or PPOs.

Discounts

The discounts negotiated with network providers are an important source of savings for CRI and necessary to offset the generous benefits of Prime. Generally, the Plans reimburse physicians according to fee structures based on the American Medical Association's standard procedure codes.[7] Procedures are associated with units on a relative value scale (RVS) established by the medical profession, and a payment factor is applied. For example, the RVS weight for a comprehensive medical history and examination (code 90020) is 17.5; if the payment factor is $5/unit, the reimbursement is $87.50. Since this system is widely used in the commercial sector, the Plans can easily compare payments to providers under CRI to those under their private sector contracts. In fact, the Plans' preexisting commercial reimbursement rates have been an important input to their negotiating targets. Final discount rates vary across areas and provider groups.

This methodology has been used by Foundation, for example, in all but a few counties. Foundation negotiated one-year renewable provider contracts with discount rates adjusted annually. These rates are subject to negotiation from medical group to medical group. In many areas, physician contracting was accomplished on an individual physician basis rather than through medical groups or IPAs. In the cases where areawide individual provider contracting was accomplished, the rates for an area or region were established by the Contractor and were considered to be nonnegotiable. In the counties of Sacramento, Colusa, El Dorado, Placer, and Yolo, Foundation has traditionally used flat procedure-based rates for reimbursing providers.

How large were the discounts actually realized? A previous RAND analysis[8] found that discount rates for about one-half of the specialties examined ranged from roughly 10 to 20 percent of the average amount allowed by CHAMPUS just before CRI. For about one-fourth of the cases, charges were greater than would have been expected without CRI, sometimes substantially so; for some, on the other hand, discounts exceeded 20 percent.[9]

Reimbursement rates for hospitals vary with the contractor but are not based on procedures performed. Foundation employs the widely used DRG system, in which the hospital receives a sum for each admission, that sum based principally on the patient's diagnosis. Partners hospitals are paid per diem rates, varying according to the unit (medical/surgical, cesarean section, etc.) in which the patient is hospitalized.

Education of Providers

The Plans are responsible for educating their network providers and staffs—a task that needs constant attention.[10] The Plans' needs to develop and complete their provider networks often affected their ability to adequately educate providers because of limited staff. At

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[7]As listed in *Physicians' Current Procedural Terminology,* issued one to several times per year.

[8]See Appendix E in Hosek et al., 1993.

[9]The Plans reported that, in specialties where we found no discount, they reviewed the rates they had negotiated. Initially, the Plans did not have the data on pre-CRI fees charged by individual providers needed to conduct their own evaluation of discounts.

[10]But the Plans did not neglect the Standard CHAMPUS providers. Workshops for these providers were held to inform them about CRI and issues of interface with network providers regarding care of Prime enrollees and to establish procedures for Utilization Management (UM), especially for mental health providers.

the outset of the demonstration, the HCF in catchment areas where enrollment in Prime was delayed provided some early CRI education to the networks. Education in succeeding months took the form of training sessions by CRI provider relations staff at provider offices, followed over the course of the demonstration by bulletins and newsletters.

Providers were informed about available medical specialists in the network, the geographical practice area of participating CRI network physicians, UM protocols, identification of Prime/Extra enrollees, prior authorizations, NASs, and CHAMPUS beneficiary eligibility requirements. Network providers were requested to call the HCF for all Prime and Extra beneficiary referrals. A provider manual and a provider directory with this information were prepared, updated, and distributed regularly.

In the Partners area, a total of 2,300 physicians, representing 60 percent of the provider network, had received this training by late 1988. Foundation also emphasized in-person education. For example, Foundation's mental health services director held orientation sessions for mental health providers; he spoke with newly contracted hospital facilities and groups and worked with providers to revise treatment plans. His goal was to develop an understanding on the part of mental health providers that CRI would approve only treatment based on medical necessity.

Even with these efforts, providers and their office staffs needed more education and information on CRI and CHAMPUS regulations than they received—particularly in the early months of the demonstration. The implementation period was too short for this educational process. As a result, network providers were not always adequately informed about CRI's managed care and innovative features. Some held that the lack of provider education regarding how to properly file claims exacerbated the claims problem. Information on why claims were denied has not been communicated clearly—if at all—nor have procedural changes. The mental health providers, in particular, have complained about this. (The Plans believe, however, that the irritation of some mental health providers is more a reaction to a curtailment of the liberal CHAMPUS benefits they have enjoyed for many years than misinformation or lack of information.)

A major problem was educating primary-care providers not to refer directly to another doctor for specialty care, but rather to obtain prior authorization and refer through the HCF. In catchment areas where Prime initially was not offered, the avoidance of prior authorization was particularly troublesome. The Plans could not enforce prior authorization because payments to network providers could be withheld for noncompliance with preauthorization guidelines only for Prime patients.

MARKETING

In establishing the Prime and Extra plan options, establishing the provider networks was only part of the job. The contractor then had to attract beneficiaries to enroll in Prime (and, if not enrolled, to use the Extra option).

General Approach

The contract required the Plans to inform all CHAMPUS eligibles of the CRI program's benefits, their freedom of choice, conditions for participation, and the special assistance available to them at the Service Centers located at each MTF. The first formal full announcement explaining CRI was a DoD letter mailed in June 1988 to CHAMPUS-eligible beneficiaries.[11] The letter told beneficiaries CRI would provide better access to physicians, new benefits, no claim forms, reduced costs, and a Service Center at their MTF to assist them with their medical care problems. In response to this letter, 70,000 requested more information and were mailed CHAMPUS Prime/Extra information packets. At least one of the Plans believed that an even better response could have been achieved if DoD had declared its support for CRI in a more explicit and sustained manner, instead of leaving it largely to the Plans to prove their own credibility.

During implementation and early operations, marketing focused on communication and outreach. Newsletters and other useful health-oriented materials were provided to Prime enrollees. Other means of information included video presentations at outlying clinics in the catchment area or on the base, radio broadcasts, presentations by contractor staff at base events, forums organized by MTF staff, articles in base newspapers, and health fairs. These marketing efforts were fairly intense; for example, during the first six months of operations, 1,500 briefings were given to 45,000 beneficiaries.

Targeting by the Plans

The approach the Plans took to marketing was not the one DoD and the MTFs expected. What DoD and the MTFs expected was a mass mailing and an extensive campaign to reach all eligibles, but the Plans preferred targeted marketing that did not change the medical care behavior of beneficiaries who did not use CHAMPUS. They feared that mass advertising of CRI's enhanced CHAMPUS benefits might draw in the so-called "ghosts"—CHAMPUS eligibles who use nongovernment sources for medical care—or encourage MTF users to switch to CHAMPUS.

The Plans were handicapped in targeted marketing because they lacked information on high-volume, high-cost Standard CHAMPUS users. This information was not available because of the data-processing problems. As information became available through NASs,[12] hospital disengagement data, CRI claims data, network hospitals, and surveys, the subcontractor's marketing program used telemarketing, focus groups, and targeted mailings to these Standard CHAMPUS users.

Marketing approaches varied somewhat with the Plan. Foundation observed that the early marketing efforts that used the mass media approaches attracted mostly retirees—the major component of the "ghost" population. The Plan redirected its efforts to reaching active-duty dependents through on-base activities. Briefings to select groups were the most effective: "Commander Calls" (once-a-month mandatory meetings), squadron briefings, active-duty wives meetings, and various support groups that involved almost exclusively active-duty per-

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[11]This mailing was hampered by the lack of accurate mailing addresses for many military families.

[12]NASs are required from MTFs for CHAMPUS reimbursement if a beneficiary lives within an MTF catchment area.

sonnel and their dependents. Presentations were also made on a regular basis at the welcome briefings for those rotating into the CRI Base. "Welcome Packets," which included a brochure on the new CHAMPUS programs and a postage-paid return card for additional information, were distributed to all new transfers. Mass media marketing, newspaper, radio, and television advertisements were curtailed.

After the first few months of operations, Partners began direct mail and telemarketing targeted at eligibles who had used CHAMPUS in the past six months or to whom NASs were issued. Partners also obtained the names of beneficiaries using CHAMPUS from 1986 CHAMPUS claims, and, later, they received more up-to-date information on high-volume Standard CHAMPUS users. Between August 1989 and April 1990, Partners made over 45,500 telephone calls to potential Prime users. In addition, Partners makes presentations to consumer councils, wives, fleet units, etc. Partners also advertises the services of the HCF without mentioning Prime. The HCF then becomes a screen to identify nonenrolled CHAMPUS users.

Queens' marketing of CRI in Hawaii also tried to avoid disrupting the pattern of medical care used by CHAMPUS beneficiaries under Hawaii's compulsory employer insurance system. Queens began slowly and did not have a dedicated marketing staff until January 1989. By mid-1990, Queens had two marketing representatives in the field. The "slow marketing" was necessary because they felt it would be counterproductive to market ahead of the ability to enroll and assign Prime enrollees to their network. The need for a symbiotic relationship between marketing, provider availability, their education, and informed beneficiaries is paramount to successful managed care. As with the other Plans, Queens' intentions to target early marketing to high-volume CHAMPUS users were thwarted by unavailability of appropriate user information.

Queens scheduled health fairs and presentations to base officers and used flyers, posters, and television to advertise CRI. A closed circuit CRI video program was created for the Tripler Medical Center Clinic's waiting areas. Presentations at the family service centers and post exchanges of the major outlying clinics were held on a regular—usually weekly—basis. Queens also marketed the services of the HCF as a key benefit of CRI. The approach was to personalize this office—stressing how HCFs can help beneficiaries and how to use HCF services. Queens was the first to utilize the HCF in this way.

Problems and Criticisms

Brochures, membership cards, provider directories, and media material such as press releases had to be submitted to DoD for approval. This hampered early marketing: Since approval for the initial CRI information packets was not received by FHC until the end of July, the packets could not be mailed until August, the first month for enrollment. However, a 24-hour DoD review period was established for press releases. A principal DoD concern in exercising review was to ensure that CRI was not advertised as "free" or "no cost."

Inaccurate addresses of CHAMPUS eligibles also impeded direct mailing. Furthermore, FHC and the Plans did not staff the marketing effort as they had planned, partly because of the short implementation time frame, which led to staff reassignments for "fire fighting." Marketing was also slowed to match the pace of provider network development and the delayed implementation of Prime in some areas.

While the Plans' marketing effort reached tens of thousands of potential enrollees and proved successful, the relatively cautious strategy was often misunderstood initially and drew criticism from some MTF commanders. Several other criticisms were leveled at the marketing effort—mostly in terms of the degree to which it fully informed beneficiaries of their options. Some felt it was too sophisticated since it evoked questions by beneficiaries directed at MTF staff who did not feel it was their responsibility to answer. The MTFs' Health Benefit Advisors accused CRI marketing staff of dispensing misinformation about Standard CHAMPUS—an area they felt was their responsibility and about which CRI staff were often not knowledgeable. CRI was faulted for not presenting the beneficiary with all three available options—Standard, Prime, and Extra. MTFs claimed Prime and Extra were emphasized to the point that beneficiaries were unaware they could still opt to use Standard CHAMPUS. (Meanwhile, Plans staff complained that the MTF staff explanation of the Prime and Extra options was inaccurate.)

Beneficiaries at first found the protocols of CRI confusing, even though the intent of CRI was simplification of the health care process. After two years, beneficiaries still were often uncertain as to which services CHAMPUS covers and which are additional services covered only by Prime—and what the difference was between Prime and Extra. Several MTF staff also complained that CRI was not marketed as a service benefit. Some beneficiaries thought CRI was a private insurance plan. They were also confused by the various insurance plans that use the same or similar sounding terms, e.g., other plans with CHAMPUS in their title, Primary, Prime, PRIMUS, Preferred, Provider, etc.

The MTFs contended that beneficiaries were not always well informed about the requirement for Prime enrollees to use the MTF for specialty care when it was available there. Prime enrollees who sought specialty care in the civilian sector without HCF permission were understandably upset when payment was denied. Beneficiaries also confused the well-understood NAS requirement with the additional need for preauthorization for inpatient and specialty care under Prime and Extra. From the MTFs' perspective, a more concerted effort was needed to counter beneficiary belief based on previous years' experience that many medical services are unavailable or difficult to obtain at the MTF. On the other hand, some CRI staff we talked to suspected Prime enrollees of choosing the MTF as their primary-care provider because they thought they would have a better chance of getting appointments at the MTF. However, priority for MTF medical care is not a benefit of Prime enrollment.

Such beneficiary problems as these highlight the need for communication and education about managed health care at a level that can be understood by the population being served. Providing this information to military beneficiaries is difficult. They are a fluid population—particularly the dependents of active-duty personnel subject to routine rotation, typically at two- to three-year intervals. They will often ignore programs that address health care insurance until medical care is needed. The increasing retired beneficiary population, with more complex health needs, frequently is found in retirement villages near an MTF, e.g., the Village West complex near March Air Force Base. Groups such as this are wary of and sometimes hostile toward perceived erosion of their health care benefits. They often resist using care outside the MTF because of the cost associated with Standard CHAMPUS.

ENROLLMENT IN PRIME

Prime enrollment is voluntary. CHAMPUS eligibles electing Prime are enrolled through the Defense Enrollment Eligibility Reporting System (DEERS).[13] Enrollment protocols specify clearly the restrictions that apply to Prime eligibility and procedures for enrollment and disenrollment and to beneficiary moves in and out of the demonstration area. Beneficiaries cannot be denied enrollment in Prime because of prior medical conditions.

Goals and Achievements

The first six-month target for Prime enrollment as specified in the contract was 5 percent of all CHAMPUS users; the target for Extra use was 40 percent. By the end of the first year, Prime enrollees were expected to be 10 percent of CHAMPUS users and Extra participants 50 percent. The contract anticipated that the Prime enrollment would be 60 percent active-duty dependents and 40 percent retirees, their dependents, and others.

By the end of the first six months of operations, Prime enrollment in the Partners area reached nearly 12,000—more than two times the targeted enrollment for this period; Foundation's six-month enrollment was also two and one-half times what had been projected—at nearly 10,000; and the Queens enrollment by the end of January 1989 was four times the projection. This level of increase over projected Prime enrollment continued for the first year. Even as late as 1993, enrollment was steadily increasing across the demonstration area (see Figure 2).

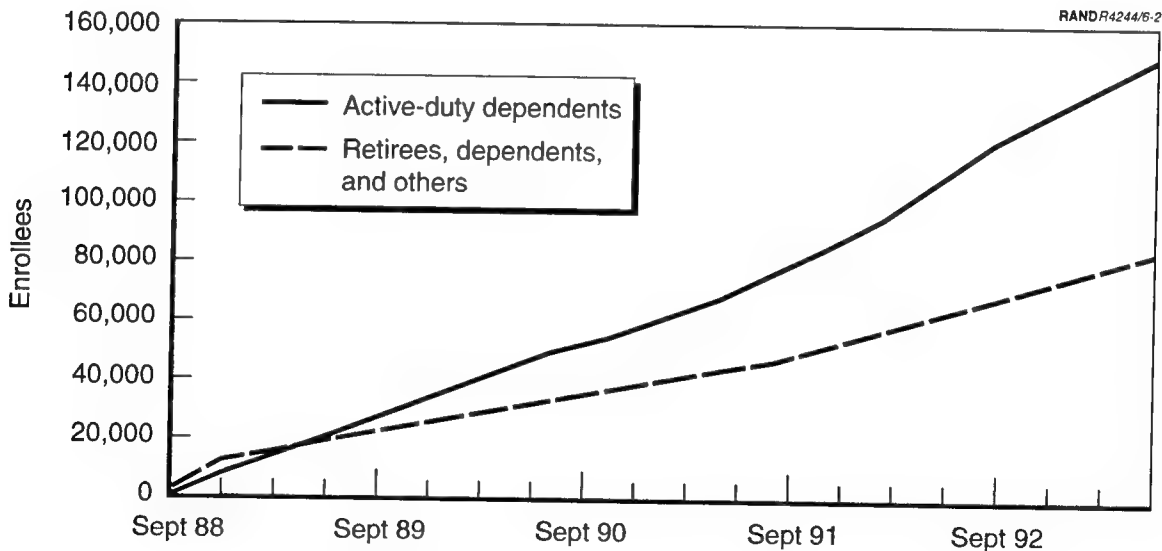Figure 2—CRI Prime Enrollment at All Sites, 1988–1993

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[13]DEERS was established in 1979 to provide a means for minimizing fraudulent use of military health benefits by unauthorized persons. Under DEERS, an individual's eligibility can be quickly verified at a health care facility. CHAMPUS claims will not be paid if the patient is not in the DEERS database or if DEERS shows the patient to be ineligible.

It is unclear why enrollment exceeded expectations by such a large margin. Part of the reason could lie in the quality of the contractor's marketing efforts. On the other hand, some of the reason for the divergence between expectation and outcome may have been that expectations were "too low." Civilian populations have been slow to enroll when HMO plans are first offered, and the CRI enrollment targets were based on this civilian-sector experience. Military beneficiaries' experience with MTFs, which resemble HMOs in some ways, may have led to early acceptance of CHAMPUS Prime.

The composition of the enrolled population changed over the course of the demonstration. In the early months, retirees were the predominate enrollees even though they represented a smaller percentage of the beneficiary population. However, by the end of the first year, active-duty dependents had become the principal source of enrollees in Prime. The preponderance of active-duty dependents (over the contractually anticipated 60 percent by 1992) may have held down the number of "ghosts."[14] If so, that could be taken as a validation of the Plans' targeted marketing approach.

Process

Enrollment was carried out largely through the CHAMPUS Service Centers, liaison offices established at each MTF (these are more fully discussed in Section 6). The enrollment process used the mail, the telephone, walk-in to the Service Center, and face-to-face presentations—individually or in groups. Enrollment in Prime entails completing an application; a membership card is issued; a handbook and Prime information are mailed to the enrollee; and eligibility is effective in five days.

Enrollment by telephone and by mail were discouraged because they are not effective in informing beneficiaries of the rules of CRI. The Plans found in-person interaction with both the sponsor (the active-duty service member or retiree) and sponsoree preferable. In-person interaction reduces confusion about the referral system and reduces errors made in seeking medical care. In the early weeks of operations, the Service Centers handled more telephone inquiries than walk-ins, but later, the Centers handled equal numbers of each. Whether the prospective enrollee walks in or telephones was and is probably affected by the closeness of the CRI Service Centers to the beneficiary population and by how the beneficiary received the information—news media, base presentations, letter, etc.

One month after operations began, it was clear that FHC's computer system, plagued with problems of claims processing, could not handle enrollment and beneficiary tracking. Enrollment staff were experiencing excessive downtime, faulty error messages, and a slow computer response. Enrollment applications and the authorization process had to be handled manually. By early 1989, applications ran ahead of the manual processing capability— the result of the malfunctioning computer system and higher-than-expected enrollment. The manual operations mode and heavy enrollment required the Plans to add more enrollment personnel than had been budgeted. By 1990, however, the enrollment system was functioning smoothly.

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[14]However, some "ghosts" apparently were attracted to Prime. Hosek et al., 1993, report that, although beneficiaries with private insurance tended not to join Prime, one-third of those with such coverage who did join dropped the insurance.

4. PROVIDING HEALTH SERVICES UNDER CRI: THE CIVILIAN SIDE

The provision of health services by network practitioners to beneficiaries required a set of new arrangements, some of which could be undertaken largely by the contractors themselves and some of which required close cooperation with the MTFs. We address the former—principally utilization review and claims handling—in this section and the MTF interface in Sections 5 and 6.

UTILIZATION REVIEW AND QUALITY ASSURANCE PROGRAMS

Utilization review (UR) and quality assurance (QA), which stress delivery of quality medical care at an appropriate level of service and at an appropriate place, are essential for CRI to succeed in containing health care costs. UR and QA programs are major components of CRI and are enhancements over what is available for standard CHAMPUS.

The traditional standard CHAMPUS program engaged in only limited UR and QA. As a fee-for-service health program, CHAMPUS has few resources to monitor the quality of the medical care being delivered under CHAMPUS. The FIs who process CHAMPUS claims have played a passive role in UR and QA since their incentive is to process claims quickly.[1]

Standard CHAMPUS oversight prior to CRI had two elements:

- NASs that are used to prevent CHAMPUS eligibles from obtaining inpatient care in civilian hospitals when the care needed is available at the MTF in the catchment area in which the eligible resides.
- Other retrospective review of care given (discussed below).

UR and QA in the Standard program were improved during the period of the CRI demonstration by the 1988–1990 implementation of (1) review by professional review organizations of inpatient care and (2) prior certification of the medical necessity of mental health care.

In CRI, a cornerstone of cost containment is a rigorous UR program, applied to all Prime and Extra patients and to other patients when possible. The UR procedures include (1) prospective review of the need for hospital care and certain high-cost ambulatory services; (2) a second opinion for selected treatments; (3) concurrent review of hospitalized patients; (4) case management for especially high-cost patients; and (5) retrospective review of incoming claims and, more generally, of patterns of care. Especially intensive review procedures were developed for mental health care. CRI's general UR program is described in the paragraphs below, followed by a discussion of the enhanced program for mental health care.[2]

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[1]Under Standard CHAMPUS, all FIs are paid on a per-claim-processed basis. They can realize additional revenue from a performance incentive in their contracts to process claims quickly. At about the same time as CRI was implemented, the FI contract for the Southeastern Region was amended to require the development of a PPO similar to CRI's Extra program, to include UM for care provided in the PPO.

[2]Further description of CRI's UM program, focusing on clinical content, is provided in Kravitz, R., et al., *Evaluation of the CHAMPUS Reform Initiative: Vol. 4, Patterns of Medical, Surgical, and Obstetric Care*, R-4244/4-

General Utilization Review Procedures

Prior Authorization. Network providers are expected to obtain prior authorization from UR staff or HCFs for referrals to specialists (only for their Prime patients), nonemergency inpatient admissions; most outpatient surgeries; second opinions not required for UR; and other selected high-dollar, high-volume services. Nonnetwork providers are encouraged to obtain prior authorization through expedited payment of preauthorized claims; providers who request prior authorization must also agree to concurrent review of the case. Guidance on the use of prior authorization is provided to hospitals and physicians by the Plans' staffs through ongoing education programs.

Prior authorization verifies that the requested medical service is a covered benefit and not available at the MTF and that it will be delivered in a cost-effective setting, if possible, by a network provider. In addition to the usual requirement for a nonavailability statement from the MTF for inpatient care and certain high-cost outpatient procedures, specialty care for Prime patients must be provided at the MTF if available there.

Prior authorization begins when the patient's physician (or hospital) requests permission from the UR nurse coordinator or through the HCF for hospitalization or referral. The nurse coordinator enters relevant admission and patient data into the computer and uses a standard reference manual to evaluate the appropriateness of the request and to assign a length of stay based on the admitting diagnosis. The coordinator can suggest other treatment options using CHAMPUS guidelines and medical review as necessary. If the coordinator doubts the admission's appropriateness or has other questions about the admission, the Plan's medical director contacts the requesting physician directly to resolve differences.

HCFs can preauthorize diagnostic tests, specialty referrals, and outpatient surgery. For the last, they use a checklist of approved outpatient surgical procedures, but they have no list of criteria upon which to judge the appropriateness of the requested service. If a procedure is not on the outpatient survey checklist, the request is referred to a physician; the HCF cannot deny a request. Prior authorization requests for special programs and therapies (physical, occupational) go directly to the UR supervisor.

Concurrent Review. Concurrent review is conducted for all Prime and Extra patients (i.e., all patients in network hospitals) and for Standard patients whose physicians voluntarily requested prior authorization. To determine this, hospital records of beneficiaries are reviewed by UR nurses within 24 hours of admission and every 2–3 days thereafter to ensure that quality care is being delivered and continued hospital stay is medically appropriate. Patients with stays longer than the length of stay projected during the prior authorization review are reviewed by the medical director. UR nurses look for opportunities to improve care, document quality problems, and, when found, refer the problems to QA staff. Providers are dropped from the network on occasion when UR/QA reviews or patient complaints uncover inappropriate practices.

Case Management. Case management is done throughout CRI—in the Prime, Extra, and Standard options. The case management staff oversee the management of high-cost, high-risk care and have responsibility for patients with hospitals stays beyond 30 days and those

requiring long-term, costly rehabilitation—e.g., premature babies, patients needing transplants, and trauma cases. Thus, case management is intensive concurrent review. Patients who are candidates for case management are often identified during concurrent review. As discharge becomes appropriate, the UR nurse coordinates with the patient, the patient's family, and the physician a discharge plan that includes home care as needed. After discharge, case managers work with the family and various agencies, including military relief, state and local social-service, legal, and financial entities.

Retrospective Review. Retrospective review, as the name implies, occurs after care has been given. It involves a review of claims for all CHAMPUS options and, in some cases, review of hospital records. The purposes are to discover fraud and abuse—e.g., claims that are improperly coded or charges for individual services that should be combined—and to monitor the provider network. Five to 15 percent of network claims and 10 percent of nonnetwork claims are randomly chosen for retrospective review. In addition, all emergency room and mental health care claims undergo this review. For the random-sample retrospective review, the claims are processed using a program that first checks for logic and consistency in claims information. Failure to pass this check results in additional scrutiny of the claim that progresses through up to three levels: (1) a first-level review to resolve clerical or technical errors, (2) a second-level review by a nurse of the services recorded on the claim, and (3) a third-level review by an appropriate medical professional for those complex cases that cannot be resolved by the nurse. Inpatient stays lasting over 30 days receive special attention during retrospective review.

Retrospective review is concerned not only with identifying individual cases where care may be inappropriate or costs high, but also with assessing patterns of practice that incur unneeded costs. As an example, in the spring of 1990, the CRI contractors identified a pattern of excessive diagnostic testing and suspected that some physicians might be inappropriately ordering tests when their offices had acquired the diagnostic equipment. Network providers were asked to identify test procedures currently being done in their offices. The contractors' medical management committee, in conjunction with community physicians, then identified procedures that are appropriately performed in physicians' offices and procedures that should be performed elsewhere. Network physicians were reimbursed only for the first group of procedures. The information collected from the physicians was then used to structure capitated, sole-source contracts for those diagnostic procedures to be performed outside physicians' offices.

For at least the first two years, reviews of provider practice patterns were severely limited by the lack of claims reports. As we describe below, the failure of a computer system made automated processing for network claims impossible during the first 20 months. For some time thereafter, there were no regular reports on the claims received and paid. Systematic, claims-based review of practice patterns was not possible. Instead, the contractors relied on the UR coordinators' experiences and other anecdotal information to identify and monitor questionable behavior.

Concluding Observation. Unlike the more limited managed-care initiatives employed by CHAMPUS in non-CRI areas, managed care in CRI is carried out by staff who are often located near the site of care and conduct on-site review of care in network hospitals. CRI's UR staff and civilian providers both indicated to us that UR staff should be located locally to facilitate interactions with MTF and civilian providers, medical records review, and a sophisti-

cated understanding of how to effectively manage care in the local medical system. As we discuss in Section 6, local UR also proved helpful in resolving differences in treatment recommendations between MTF physicians, network physicians, and contractor staff.

UR Procedures Specific to Mental Health

Mental health services account for a large fraction of CHAMPUS costs (about 20 percent) because CHAMPUS includes an unusually generous mental health benefit[3] and the MTFs provide little mental health care to CHAMPUS eligibles. Therefore, CRI developed an unusually intensive UR program for mental health. A mental health professional liaison committee developed mental health protocols designed to achieve (1) accurate initial diagnosis, resulting in a treatment plan employing the most effective care, (2) a decrease in "unnecessary" treatment, and (3) treatment by the least costly provider and setting appropriate for the clinical circumstances. To achieve these goals, the committee developed explicit clinical criteria or guidelines that delineated appropriate care. Most criteria apply to all mental health patients; for example, psychiatric hospitalization is authorized, regardless of diagnosis, when the patient is suicidal, a threat to others, or unable to care for himself.

These criteria are applied by specialized mental health staff as part of CRI's routine prospective review, concurrent review, retrospective review, and case-management procedures. The reviews are more comprehensive for mental health services, and they require more clinical documentation by providers. This intensive program applies to all mental health care—inpatient and outpatient—delivered by network and nonnetwork providers in the demonstration area.

All inpatient care in network and nonnetwork hospitals requires prior authorization and is subjected to concurrent and retrospective review. During prior review, UR staff identify opportunities to substitute outpatient treatment for hospitalization and, for children, a foster parent program in lieu of residential treatment centers.

Outpatient care generally is not reviewed until the seventh visit. Before the seventh mental health visit for any patient, the provider must submit a treatment plan that delineates treatment goals and plans. Based on this and updated plans, additional outpatient treatment is authorized in 10-visit blocks. All referrals for psychological testing must be preauthorized, usually by a reviewer with expertise in testing.

Retrospective review of mental health care was designed to identify specific patients and providers, or types of providers, who have used resources unnecessarily. Through claims information on, for example, length of stay or the services provided by individual providers, utilization patterns falling outside the normative range are identified. This screen can disclose abusive practices, such as multiple providers inappropriately caring for the same patient or multiple modalities of treatment. The particular problems identified in this way have varied from locality to locality within CRI. Consequently, specific initiatives to change patterns of care have varied.

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[3]Government Accounting Office, *Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans,* HRD-92-20, November 1991.

The lack of data that initially limited review of practice patterns for other types of care was, to some extent, mitigated by the availability of the treatment plans submitted for mental health authorizations. But there were other early problems specific to mental health UR. For example, there were insufficient numbers of HCFs specializing in mental health in the early months of CRI, and the provider protocols for handling mental health were delayed. As mentioned above, mental health and crisis intervention in San Bernardino and Riverside Counties were provided under subcontract until 1990. This extended organizational structure added complexity to training, credentialing, and integration for Partner's mental health UR staff.

Quality Assurance

Contractor staffs responsible for the QA program monitor and evaluate patient care and clinical performance of health care providers, and a cross-Plan QA committee coordinates QA studies for program improvement. QA is focused on problem identification, resolution, and patient-care improvement. Physician credential/recredential review and formal quality-management procedures are used to identify, track, and resolve all Potential Quality Issues (PQIs) that affect the health care of beneficiaries.

QA is closely tied to UR. Quality of care issues are often identified in the course of UR concurrent review by nurse coordinators who make on-site hospital visits and review medical records. These nurses or, sometimes, HCFs file PQI reports if a problem is suspected. QA nurses review the PQI. If there appears to be a quality problem, they refer the case to the medical director for further review and corrective action.

Although QA is required only for Prime enrollees, the Plans incorporate it in as much Standard and Extra beneficiary care as is possible using the same criteria and standards as for Prime patients.[4] Plan staff indicated that quality review of Standard patients in non-network hospitals is more difficult because the Plans are not also conducting UR in these hospitals (except for mental health patients).

In addition to identification by UR nurse coordinators, PQIs can come to attention through claims review and grievances. Claims review is discussed in the next subsection. The grievance procedure, whose various steps are spelled out in a protocol and apply throughout CHAMPUS,[5] was established to ensure timely and fair evaluation of the concerns voiced by beneficiaries about their care. Between September 1988 and January 1992, only 111 grievances were filed in the CRI area (out of 4.8 million claims). The paucity of complaints is mirrored in RAND's beneficiary surveys, which indicate greater satisfaction with care under CRI than elsewhere in CHAMPUS.[6] Surveys conducted by the Plans and MTF staffs also report beneficiary satisfaction with both the program and the quality of medical care received. There were some problems, but these were related not so much to quality of care as

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[4]The military departments have developed a QA program for care delivered in MTFs.

[5]This protocol is indicative of the complexity of the managed-care procedures through which CRI operates. It includes nine requirements: the format for informing the beneficiary about the process, processing time, information to be collected, staff responsible, evaluation criteria, privacy safeguards, and procedures for notifying the beneficiary, disposing of the file, and appealing to a higher level of review.

[6]See Sloss, Elizabeth M., and Susan D. Hosek, *Evaluation of the CHAMPUS Reform Initiative: Volume 2, Beneficiary Access and Satisfaction,* Santa Monica, Calif.: RAND, R-4244/2-HA, 1993.

to billing (discussed below), the referral process, and MTF accessibility (discussed in Section 6).

CLAIMS HANDLING

Claims for reimbursement by the Plans are submitted by network providers for Prime and Extra patients and by nonnetwork providers or beneficiaries otherwise. Here we discuss the problems that arose early in CRI in computerized processing of the claims and the procedures for appealing denied claims.

Problems and Adaptations in Claims Processing

Claims processing for the CRI demonstration was unusually complex because of the managed-care innovations and a two-track processing system. Standard CHAMPUS claims were processed by a subcontractor, BCWA, while Prime and Extra claims were processed directly by FHC. CRI had other requirements that added to operational difficulties:

- Because CRI was being conducted within the CHAMPUS program, the explanation of benefits incorporated in beneficiary claims statements had to be unusually comprehensive and had to be approved by DoD.

- Address changes for Prime enrollees moving out of the CRI area—common for military families—had to be incorporated in the data systems immediately so their disenrollment would not cause a period of ineligibility.

- Claims passed through complex edits for logic and consistency to support a key component of the initiative—UR. Editing problems plagued the processing function into 1990, causing some improper processing of denials for hospitalization.

- Since the CRI contract was, in effect, a new FI contract, all civilian providers had to be recertified for CHAMPUS payment.

- The creation by DoD of a new format for extracting summary information from claims required extensive programming and modifications to BCWA's existing claims-processing system. The CRI contract was the first to incorporate the new format, which also proved difficult for other FIs to implement.

- FHC needed to develop a computer system to handle Prime and Extra claims processing, and to support a myriad of administrative and reporting requirements. The computer system was tested prior to the start of operations in August 1988, but it proved incapable of handling the volume of activity required for full implementation of CRI.

Both claims-processing systems had a difficult time responding to these challenges. In particular, the FHC computer system was unusable, and personnel trained for an automated system had to be retrained for operations in an ineffective manual mode. Every functional area of CRI was adversely affected. The failure deprived the Plans of the data needed for marketing, costing, and network provider development and education. Network claims processing was almost nonexistent until April 1989.

To bring about needed improvements, in early 1989, FHC contracted with Electronic Data Systems (EDS) for assistance in resolving their computer/claims problem. The contract

called for new hardware and software to be operational by April 1989. FHC personnel would process in-network claims with the new system. The original system would be retained and dedicated to enrollment, the HCF operation, and other report and administrative tasks.

Still, it was not until early 1990 that significant parts of claims processing met contract standards.[7] The Plans had access to claims data for analysis by the third quarter of 1991. As late as 1990, there had been no CRI computer-produced information for the Plans' use to determine how CRI was affecting health care services or to monitor the provider network. Furthermore, the low claims completion factor for both BCWA and FHC during the first year and the unavailability of information on CHAMPUS users and provider practice patterns made estimating costs for the succeeding option periods pure guesswork and delayed the bid/price-adjustment process.

Beneficiary Claims Issues. Duplicate application of deductibles also caused claims payments confusion. This resulted initially because neither FHC or BCWA had user history from the former FI—Blue Cross/Blue Shield of South Carolina; once the demonstration program was under way, FHC and BCWA also failed at times to coordinate this information. However, it should be noted that this lack of coordination of yearly deductibles occurs in non-CRI areas with a new FI or among FIs responsible for different regions. Nevertheless, as late as the summer of 1990, the FHC and BCWA claims-processing systems did not interface well and double deductibles were still occurring within the demonstration area for non–Prime enrollees who used both network and nonnetwork providers.

Beneficiary dissatisfaction also resulted from inappropriate attempts by network providers to collect unpaid fees from beneficiaries. Some of these attempts were made when the Plans fell behind in reimbursements (see below). Others arose when these providers billed for the difference between their fees and costs allowed under CRI. Such billing, which came on top of the deductible and copayment, was in violation of the network participation agreement.

Eventually, FHC made headway against beneficiary claims issues. Between August 1988 and March 1989, 98 percent of the beneficiary calls were claims related. By 1990, claims calls dropped to 35 percent. Very old claims that had not been paid were being processed and corrected manually.

Provider Reimbursement and Relations. The data-poor environment forced adaptations in reimbursing providers. During October and November 1988, providers were paid 70 percent of their historical CHAMPUS-billed charges. By December 1988, FHC went into an automatic payment program; claims were logged in and paid at 70–75 percent for claims over 30 days. There were no Explanations of Claims (EOCs), which tie payments to patients' treatments. Their absence complicated providers' bookkeeping because payments could not be tied to services delivered. Hospital billing departments had to be contacted so they would not try to collect from patients. Even so, attempts at collection from patients occurred, and correcting this irregular action consumed considerable time of the MTFs' CHAMPUS Health Benefits Advisors, MTF Command staffs, and the Plans.

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[7]David P. Baine, "Potential Expansion of the CHAMPUS Reform Initiative," statement before the Subcommittee on Military Personnel and Compensation, Committee on Armed Services, House of Representatives, GAO/T-ARD-90–17, March 15, 1990.

In the absence of an efficient system for processing claims during the 1988–1989 period of operations, the Plans resorted to intensifying communication, cooperation, and coordination with FHC and their networks and attempted to maintain as effective a manual process as possible. While problems with claims payments were being corrected, Plans' provider relations staff had to devote significant amounts of time to helping providers with claims issues. The Plans saw their main goal in the 1988–1989 time period as maintaining their provider network, and the claims-processing issue was stressing provider relations. At the peak of the problem, in late 1988 to early 1989, providers left the CRI networks, some sued, and others refused to accept any CHAMPUS patients. At one Plan, turnover was 20 percent. The problem was more severe in mental health, where all claims are reviewed in an effort to stem overuse of the generous CHAMPUS mental health benefit.

Plans had to augment their provider relations staffs to handle provider complaints, to obtain partial payment on provider claims, and to maintain and reconstitute the networks when providers had left CRI. Thirty full-time staff were added for claims work at one Plan:[8] 60 percent were needed to work with providers, the remainder to handle beneficiary complaints. Marketing staffs were also enlisted to address claims issues. The Plans' costs for this unanticipated activity were significant, and their administrative budgets at this time were not sufficient to cover adding staff for claims resolution. With Plans' staffs working on shoring up this fragile situation, auditing provider claims for compliance with contractually agreed-to fees was not possible. It also was not prudent to pressure providers relative to their ignoring CRI's managed health care concepts and protocols. For example, UR enforcement had to be tempered because of the claims problem since it was a potential source of additional provider aggravation.

As of late 1990, a few providers with claims dating back to 1988–1989 were still looking for settlements. The problem of these old claims—whether lost or denied—was usually not adequately explained; EOCs were inaccurate or incomplete.

Claims-Related Appeals

Appeals of denied reimbursements are handled by CRI beneficiary services.[9] Beneficiary services representatives receive several days of training on CRI, CHAMPUS, and customer relations service. Over 1989 and into 1990, the work of the beneficiary services representatives was focused on correcting claims and adjudicating disputes resulting from untimely and inaccurate claims processing. The inadequate claims operation created the need for additional beneficiary services staff to handle the high level of beneficiary and provider dissatisfaction.

The Plans handled network provider appeals and disputes, and BCWA those involving out-of-network providers. FHC supports the plans with network appeals. Most appeal requests are either written or phoned in. Priority is given to requests by the MTF, DoD, and provider complaints.

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[8] Total office staff numbered about 250.

[9] As are grievances over quality of care and priority communications with government officials, attorneys, and base commanders.

Appeals review employs the FHC medical director, the UR and claims staffs, and other appropriate personnel as needed in a process that can include (1) an analysis of major-procedure outcome rates, e.g., after-surgery infections, general mortality, maternal and neonatal mortality; (2) random review of outpatient records to evaluate standards of care; (3) studies of such medical procedures and conditions as cardiac catheterization and infant prematurity. As a result of such reviews, FHC can recommend changes in the Office of CHAMPUS (OCHAMPUS) policies and input for future policies.

A denied claim upheld in review is reported back through the cognizant Plan to the beneficiary and to OCHAMPUS.[10] If initial review supports an overturn of the denial, the appeal is reviewed by an appeals committee. The outcome of the review is reported to the beneficiary, OCHAMPUS, and to the quality and policy staffs at FHC and the Plans.

Between September 1988 and January 1992, over 4.8 million Prime and Extra claims were processed. There were only 1,533 appeals (0.03 percent of claims).

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[10]During 1988–1990, nearly 3 million claims were filed, and about 600 were denied and then appealed. Of the latter, 375 were upheld on appeal, 50 were partially upheld, and 175 were reversed.

5. COORDINATING CIVILIAN AND MTF HEALTH CARE: RESOURCE SHARING

As stated in Section 2, one of CRI's major purposes was to improve the coordination of health care delivery to CHAMPUS beneficiaries by military and civilian providers. It was believed that better coordination would serve CRI's other policy objectives—containing costs and improving access to and continuity of care while maintaining quality of care.

In the years prior to CRI, CHAMPUS and the MTFs were poorly coordinated. At the same time, beneficiaries were trying to use both systems, often switching back and forth. They would go to the MTF when they could because it was free but more and more often would turn to CHAMPUS because they had difficulty in getting appointments at the MTF, which were limited by armed-service personnel and budget constraints. Partly as a result, CHAMPUS had grown significantly—while MTF usage actually shrunk. As MTF inpatient admissions decreased by 64,000 between FY85 and FY87, CHAMPUS inpatient admissions increased by 50,800. Ninety-eight percent of these admissions were for beneficiaries living in MTF catchment areas. A 2.7 million decrease in MTF outpatient visits was accompanied by a 2.5 million increase in CHAMPUS-paid outpatient visits; 88 percent of these were in MTF catchment areas.[1] These data suggest that by FY87 MTFs had some unused capacity.

Thus, DoD had medical care resources that were underutilized by beneficiaries who were dissatisfied with access to and continuity of care. Furthermore, DoD estimated that MTF care cost significantly less than that of CHAMPUS. Since roughly two-thirds of CHAMPUS beneficiaries' health care demand was still being met by the MTFs, inefficiency in using the MTFs could have offset small gains on the civilian side from CRI. As a result, CRI incorporated features intended to increase MTF utilization by more closely linking the civilian and military systems.

CRI has two main features to create or improve CRI-MTF linkages: a resource-sharing plan to fully utilize MTF capacity by augmenting depleted resources and staffing and HCFs to appropriately channel patients to civilian or military providers. It was hoped that these two features would enable the contractor to promote maximum use of the MTF, when a financial incentive to do so existed anyway through FHC's assumption of the responsibility for the cost of all CHAMPUS-financed care.[2] In this section, we describe resource sharing and in the next the HCF.

Resource sharing was a response to the personnel and budget limitations mentioned above.[3] In our interviews, staff at the MTFs described resource constraints that parallel what has been reported by government auditors, inspectors, various panels, and others who have looked at problems of military medical facilities. Because of unresponsive and resource-defi-

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[1]Government Accounting Office, *Defense Health Care—Workload Reductions at Military Hospitals Have Increased CHAMPUS Costs*, HRD-89-47, 1989.

[2]As discussed in Section 2, in the case of procedures for which cost per unit of utilization (bed day, visit) were average or low, the contractor initially had no financial incentive to maximize MTF use. Increases in MTF utilization resulting from resource sharing inappropriately led to lower contract payments.

[3]Shortly before CRI, OCHAMPUS had begun a civilian provider–MTF partnership program with similar goals. This program is discussed below.

cient military medical systems, many MTFs lack adequate facilities, nurses, technicians, and other support for medical care. In order to maintain uniformed provider skills—e.g., surgical—some have felt it necessary to establish agreements with civilian hospitals to allow them to treat patients there.

Resource sharing, a key feature of CRI, allows the Plans to provide the MTF with resources it can use to provide additional services to CHAMPUS beneficiaries. With the approval of the MTF Commander, the Plans can use resource sharing to augment MTFs so that their medical care can be provided to a greater number of CHAMPUS eligibles. (By law, the funds so provided can be spent only on care for CHAMPUS eligibles.) Resource-sharing proposals can be initiated by either the MTF or the Plans, but the final agreements must be acceptable to both. Once an agreement is signed, the cognizant Plan will procure the required resources and pay for them directly, not through the claims system.

ESTABLISHING AN AGREEMENT

To satisfy both MTF and Plan requirements, resource sharing requires a methodology to identify and execute advantageous agreements. The methodology has several components. The first item is the MTF commander's and the Plan's identification of a need and the assessment of their capability to address that need.

Second, a determination must be made as to whether the MTF providers can care for sufficiently more CHAMPUS patients to offset costs from two sources: the additional staff and equipment obtained through resource sharing and any additional health care demand from CHAMPUS eligibles induced by the additional MTF capacity. Because the Plans are at financial risk from resource-sharing agreements, they tend to be conservative and adhere closely to cost/benefit analysis. The Plans estimate salary, wage rates, and discounted fees for staff they are providing; their proposed work hours in the MTF; and equipment/supply purchase/rental costs. They then calculate total cost and compare that with projected CHAMPUS savings based on potential CHAMPUS workload expected to transfer to the MTF.

An MTF enters into resource-sharing arrangements only if it can accommodate the augmentation without adversely affecting other areas of the hospital or clinic and if the staff believes the resources will be of acceptable quality. The MTF attempts to estimate the increase in its workloads and costs that will occur with resource sharing, including ancillary services. However, the MTFs have not had the data or analytic tools necessary for these calculations.

The cost of any resource used for both CHAMPUS and non-CHAMPUS beneficiaries (e.g., nurses who care for all patients on a ward) is allocated proportionately to the number of CHAMPUS and non-CHAMPUS patients. The Plans then pay for the CHAMPUS portion and the MTFs for the remainder.[4]

Once a resource-sharing opportunity has been identified, coordinated with the MTF Commander, and its cost-effectiveness verified, a written agreement is prepared between the specific Plan and MTF that covers the terms and conditions of the resource to be shared. Terms and conditions may include minimum CHAMPUS caseloads to be recovered, the MTF-pro-

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[4]In some cases, relatively inexpensive resource sharing has been so cost-effective that treating only a few CHAMPUS beneficiaries recovers the cost of the resource-sharing initiative and the status of patients using the service is no longer an issue.

vided ancillary and/or clerical support, the specific specialty being provided by the Plan, minimum liability coverage, hours, and services to be performed. The Plans forward agreements to FHC for approval, and FHC informs OSD (HA) in their monthly reports of the status of resource-sharing agreements.

The Plans are responsible for the maintenance of accurate records to document the activities pursuant to resource-sharing agreements. Since the shared providers, support personnel, equipment, and supplies will be in the MTFs, the full cooperation and assistance of MTF personnel are necessary to maintain accurate data and reporting of resource-sharing activities.

ADVANTAGES OF RESOURCE SHARING

Resource sharing can be used to acquire specialists for the MTF who are hard to retain as uniformed providers—orthopedists, cardiologists, surgeons, obstetricians/gynecologists. And it is not necessary to add personnel in full-time staff increments; resource sharing can fund a half-day's work per week by a single specialist. Even small investments can result in large savings. At a major clinic, resource sharing was used to obtain a child psychiatrist and social worker to replace rotating mental health providers. Substantial CHAMPUS costs were avoided since the patients involved did not need to be referred to the civilian sector.

But it is the lack of personnel below the nursing level—clerks and technicians—that has long been identified as curtailing MTF provider treatment capability. Since the Plans can pay competitive wages—which the MTFs have been unable to do because of rigid Government Service pay scales—nursing, technical, and clerical support can be brought to the MTFs through resource sharing if, in so doing, enough additional CHAMPUS patients can be seen to pay for it. With this in mind, low-paid clerks at one MTF have been added to free radiology technicians from filing duties, and more radiology technicians have been acquired to allow more intensive use of expensive CAT Scan (CT) and Magnetic Resonance Imaging (MRI) equipment. Resource sharing was the vehicle to provide 13 full-time equivalent staff for a large nurse midwifery program. This program has recaptured 85–100 percent of the CHAMPUS-eligible births per month in this catchment area. At one medical center, it has provided the nursing staff to fully utilize the neonatal intensive care unit.

Resource sharing can provide needed resources other than personnel. It can enhance MTF capability by, for example, funding equipment installation, prostheses for hip replacement, and medical transcription equipment to free up time for medical personnel to see patients. Generally speaking, MTF commanders have been impressed with the buying power of FHC and the Plans and with the speed with which they can obtain resources.

Resource sharing could in theory support renovation or rehabilitation of MTF facilities—though CRI's limited duration has in practice restricted such applications. Medical centers and recently built MTFs are in the best position to propose such efforts, because modifying their physical plant is likely to be less costly than doing so for a facility that has less flexible space or is older. As an example of such resource-sharing opportunities, consider that inpatient substance-abuse treatment and psychiatric care account for over 30 percent of CHAMPUS expenditures. Most MTFs have enough staff to provide mental health treatment to active-duty personnel only. Proposals to open unused wards for inpatient mental health and substance abuse treatment for CHAMPUS beneficiaries are therefore popular. At one MTF, resource sharing provides an alcohol-abuse counselor, physicians, and nurses. It was

estimated that using resource sharing to provide capital investment and staff for a 30-bed psychiatric unit would reduce the $12 million CHAMPUS bill for providing these services by $4 million. However, because the CRI contract was at the time expected to expire in 1993, this major MTF renovation was not attempted because there was not thought to be sufficient time to recover the costs of expansion. Generally, extensive MTF facility upgrade and renovation proposals have not been judged cost-effective, in part because of the limited time to recover the costs.

In addition to the potential savings of CHAMPUS money, resource sharing also generates other benefits. For example, continuity of care may be easier to maintain when the patient can obtain specialty care within the MTF rather than having to seek care in the civilian community. Also, because resource-sharing physicians are not subject to military training exercises and rotation, they provide the MTFs with stability in medical care delivery, particularly in the previously understaffed area of primary care. Quality of care can be enhanced with resource sharing. When the MTF has an inadequate number of specialists, patients who find civilian care too expensive continue to seek care inappropriately from MTF primary-care providers. Adding needed specialists also lessens uniformed providers' frustration over their inability to satisfy the patients' medical needs.[5]

Another advantage of resource sharing is its leverage potential to persuade reluctant civilian hospitals to join the provider networks. Augmenting capabilities within the MTF can take patients away from any hospitals that may have enjoyed a monopoly as the only provider for certain medical conditions. Their cooperation as a network provider may be necessary for them to retain their own patient load.[6]

Since resource-sharing patients count toward MTF workload, on which their budgets are determined, MTFs have received credit toward future resources, albeit delayed, from CRI-subsidized patient care.[7] The counterargument is that resource sharing creates MTF facility and other variable costs that—while difficult to measure—are real (see "The Burden on the MTFs" below).

DELAYS IN IMPLEMENTING THE PROGRAM

While resource sharing provides payoffs for the Plans, the MTFs, and the beneficiaries, the program was not easily effected, and there have been delays and problems all along in reaching and implementing resource-sharing agreements. The rest of this section traces the history of resource sharing and the factors that have weighed against it in some cases.

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[5]A contrasting view was expressed by an MTF clinical head responsible for a resident training program. He worried that the civilian specialists in a partnership program were becoming a crutch and the residents were not stretching their knowledge of patient treatment. This department head felt that patient outcomes would often have been just as good under family-practice or internal-medicine providers as under subspecialty care.

[6]Where monopoly conditions do not apply, providers (especially individual physicians) may leave the network if resource sharing draws too many patients (see "Delays in Implementing the Program," below).

[7]This is unlikely to be the case in the future. DoD is moving toward capitated financing for MTFs, which should eliminate the connection between workload and future resources.

An Initial Delay

In 1988, MTF commanders and staff were enthusiastic about the resource-sharing concept and the promise it held for expanding or restoring the capabilities of their facilities. However, when the Plans began to negotiate resource-sharing agreements with the MTFs, they found that only limited situations could be cost-effectively corrected by resource sharing. The problem lay in the complicated price-setting formula established in the CRI contract. As explained in Section 2, the prospective price stipulated in the contract is subject to retrospective adjustments, depending in part on MTF workloads (e.g., admissions, bed days, outpatient visits). If the total MTF workload in the demonstration area increases, the payment to the CRI contractor may decline. Hypothetical calculations showed that resource sharing would be cost-effective only for low-volume, high-cost medical procedures, such as kidney dialysis, when the CHAMPUS savings would exceed any decrease in the contract price caused by the added MTF workload. Thus the Plans were deterred from implementing almost all kinds of resource sharing. As of February 1989, there were only two major signed resource-sharing agreements: Partners had two therapeutic radiology technicians at the Naval Hospital San Diego, and Foundation had placed a nephrologist and renal diagnosis equipment at Fort Ord for acute, nonchronic care (a low-volume/high-cost procedure).

OASD (HA) staff, their consultants, and FHC spent several months revising the cost-allocation formula so that the contractor would not be penalized for MTF utilization increases due to resource sharing. Agreement was reached early in 1989, and resource sharing became available to MTFs by spring.

MTFs were uniformly disappointed with the resource-sharing delay. They had hoped resource sharing would fill gaps in staffing and even upgrade facilities in order to allow higher levels of occupancy. This did not become a reality until well into 1989. In the meantime, MTFs intensified their use of an alternative—the partnership program.

From Partnerships to Resource Sharing

A civilian provider partnership program had become available to all MTFs just prior to CRI. This nationwide program allows MTF commanders to sign agreements with civilian providers under which the civilian providers can treat CHAMPUS beneficiaries[8] in the MTF at CHAMPUS expense; the providers file claims for payment at discounted rates. The program's purpose is thus similar to that of resource sharing, but it is less flexible and more of an administrative burden on the MTFs, as explained below.

When CRI became operational on August 1, 1988, there were 15 active partnership agreements in the demonstration area. By October 1989, there were 89 partnership agreements covering an unknown number of providers. (Partnerships frequently involve more than one provider.) The growth in the number of partnerships in the demonstration area can partly be attributed to the delay in resource sharing.

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[8]In terms of patients covered, MTFs would have preferred direct contracting for civilian assistance since contracted personnel can treat all populations—active-duty and Medicare, in addition to CHAMPUS, eligibles. However, federal contract requirements are cumbersome and time consuming. Partnerships have not generally been considered contracts and can more easily be executed.

Under CRI, OCHAMPUS designated FHC as initial receiver and reviewer of the MTF partnership agreements in the demonstration area. FHC coordinates review and approval of partnership agreements with the Plans, whose personnel work closely with MTF staff, sharing their negotiating experience and information regarding provider networks. The contractor is responsible for reimbursing services rendered under the partnerships—but prior to their renewal had no control over the salaries negotiated under those it "inherited."

Once the contract price adjustment formula was corrected, resource sharing was under way in the late spring of 1989. MTFs had an incentive to shift to resource sharing because partnerships only furnish providers who can bill CHAMPUS, whereas resource sharing can also be used to acquire other resources such as support personnel, supplies, and equipment. Partnerships are also more of an administrative burden on MTF staff and on the civilian providers involved because the latter must file claims, and thus must be audited to ensure fair billing practices, whereas under resource sharing, providers are paid directly by the Plans. In the prevailing CHAMPUS claims-processing environment, this was a distinct advantage for the providers.[9]

Early resource-sharing activity focused on partnership conversion to resource-sharing agreements. Given the claim-free resource-sharing environment, if the provider salaries under the partnership agreement were satisfactory to the Plans, conversion was assured. These conversions were well under way by the end of 1989. Their conclusion was slowed in most cases because existing partnership agreements were allowed to expire before conversion and the Plans usually endeavored to negotiate lower salaries with these providers for resource sharing.

Some partnership conversions requiring Command-level approval above the MTF have encountered further delays. Also, arrangements to convert partnerships that are critical to an MTF's teaching program and/or ability to provide specific medical services had to be negotiated more carefully than others. The loss of such partnerships could negatively affect existing MTF capability. The Plans have learned to consult the MTF on those partnerships that need protection.

The claims issue also affected some partnership conversions. Civilian partnership providers were concerned about FHC's ability to meet financial obligations. These physicians preferred to make arrangements directly with the MTF.

By 1990, most MTFs in the demonstration area began to focus on resource sharing and used partnerships to fill gaps in coverage in two kinds of circumstances: when resource-sharing agreements could not be negotiated or when there would not be a decrease in CHAMPUS costs by enough to be cost-effective. Figure 3 graphs the growth and decline of partnerships and the rise in resource-sharing agreements and shows that, as resource sharing has increased, partnerships have declined. In the demonstration area, by January 1992, there were only 18 active partnerships. The partnerships that existed at that time were predominantly for optometrists and pediatricians, including several subspecialties in the latter.

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[9]Partnerships have other deficiencies relative to resource sharing. For example, partnership physicians have usually been less well integrated into the MTF. Typically, they do not attend MTF educational meetings, perform rounds at the MTF, or participate in the MTF quality assurance process. They may also not have inpatient privileges. This lack of integration results in extra burdens on MTF physicians and can work against continuity of care.
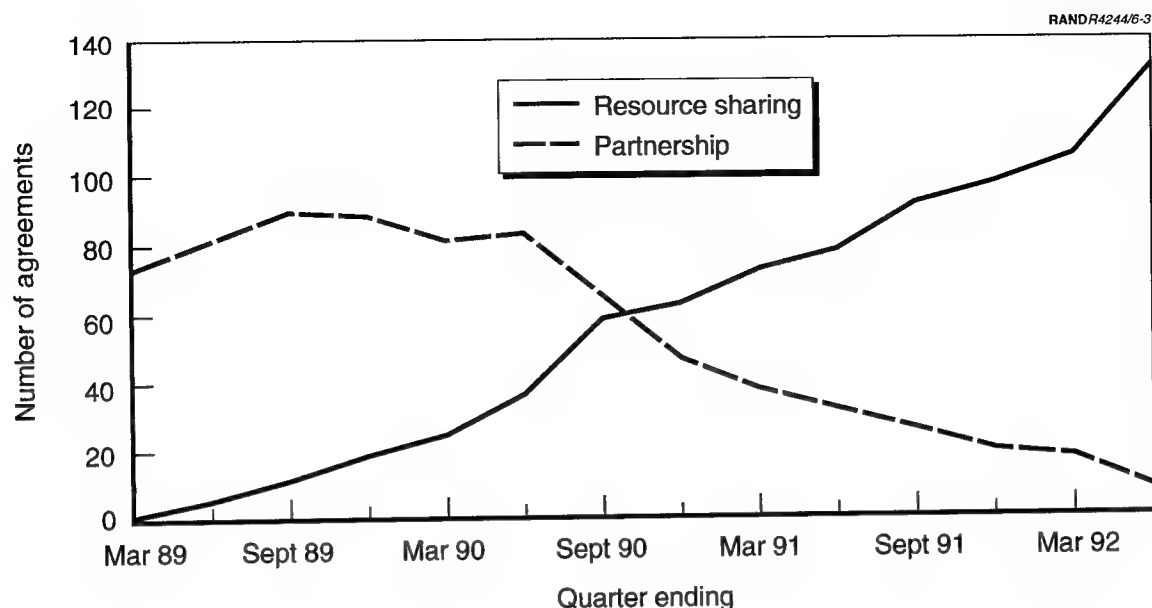
Figure 3—History of Partnerships and Resource Sharing in CRI

Further Delays in Implementing Agreements

Even after clarification of the contract price effects, it took over a year for resource sharing to really take off (see Figure 3). The Plans and MTFs disagreed about where the initiative for resource sharing lay. The Plans believed the MTFs were in the best position to identify resource-sharing opportunities; the MTFs believed that those knowledgeable about where and how CHAMPUS dollars are being spent are able to identify opportunities for their savings. In fact, resource-sharing proposals have come from both sources in a variety of ways: the MTF's identification of needs that resource sharing can remedy, MTF surveys, MTF staffs—particularly clinic directors, Plans' UM and HCF staffs, and service area managers.

From the Plans' perspective, the early MTF recommendations were superficial, with incomplete data and analysis. This is partly attributable to early misunderstanding by the MTFs of the parameters of resource sharing. The MTFs also lack trained cost-benefit analysts and adequate computational capability, have insufficient geographic and demographic beneficiary data, and poor information on operating costs and what medical services are billed to CHAMPUS—and by whom. On operating costs, for example, determining and recovering costs attributable to resource sharing or partnerships require an individual patient billing system in the MTF that identifies, for example, information on the patient category (CHAMPUS, active duty, etc.), the patient's disease, associated laboratory costs, X-ray costs, pharmacy costs, etc. MTFs currently lack data, computer technology, and analysts to develop such a "cost slice" per episode of care. Lacking good data, MTFs have had to resort to aggregate data on historical workload, utilization, visit rates, staffing standards, and personnel productivity. Some MTFs have adopted Air Force manpower modeling standards for

the productivity part of this analysis.[10] NASs are an indicator of potentially fruitful resource sharing but are, in themselves, insufficient. The dearth of analytic capability caused apprehension on the part of some MTF commanders about making commitments they were not sure they could keep. While the need for MTFs to have the ability to obtain data and analyze it is universally recognized, this capability is slow in being realized—and then at only a few hospitals.

Working out the liability language for the agreements to the satisfaction of the contractor, provider, and MTF, and accommodating military regulations added delay at first. Early agreements took about three months to conclude; many took longer. Most MTFs were impatient to exploit resource sharing and perplexed that the Plans had not acquired the necessary staff to process the proposals they had put forth. MTFs hoped, however, that once the details of liability, indemnification, and credentialing were agreed to by the lawyers, a resource-sharing agreement would become generic and future ones negotiated speedily.[11]

In assessing the cost-effectiveness of resource-sharing proposals, the Plans reviewed the historical workload in the specialty under consideration and the cost of the cases that would be referred outside the MTF. The Plans were hampered in this process because they did not have detailed CHAMPUS costs. Furthermore, it was not always prudent to move forward with resource sharing if the network would be disrupted, particularly when the area in question did not have a competitive provider market, e.g., Hawaii and the Monterey Peninsula. Network providers join and remain in networks because of the volume of patients they expect to treat. Resource sharing can affect that volume and, especially in uncompetitive markets, lead to losses from the network. The rotation of MTF staff also added considerable uncertainty to resource-sharing decisions. A cost-reducing resource-sharing agreement could become more costly and even infeasible with the temporary or permanent loss of MTF personnel.

The analysis of each proposal to determine its cost-effectiveness was thus time consuming. In the first year, the Plans were struggling with very heavy staff demands brought about by the claims-processing problems. By mid-1989, the Plans began to enhance their staffs to meet resource-sharing implementation needs, and organizational changes continued during the first two years. For instance, at the beginning of CRI, Queens had no resource-sharing coordinator. By the summer of 1990, they moved resource-sharing operations under Provider Relations, and a coordinator was in place.

Delays also occurred when Plans had trouble locating qualified providers who would accept discount rates sufficient to fit the Plans' cost/benefit analysis formulas. This was the case for Partners in their discussions with MTF staff at Camp Pendleton. The latter were impatient to obtain obstetric/gynecology services, but Partners could not reach agreement with the providers that the Naval Hospital hoped to engage. Resource sharing in this catchment area did not start until late summer in 1990, and then it was for a different initiative. At the Naval Hospital San Diego, a revised contract for nurse-midwives was protracted as Partners sought to obtain a lower price on the rebid for this contract.

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[10]OASD(HA) is currently developing engineered staffing standards to allocate resources for peacetime health care activities within fixed medical treatment facilities. A Joint Healthcare Management Engineering Team has responsibility for standard development, reporting to the Assistant Secretary of Defense for Health Affairs and the Service Secretaries.

[11]Over the course of the demonstration, some progress was made toward this goal.

Even with these delays, however, by the end of 1990, resource sharing had supplanted partnerships as the most common means of bringing civilian providers into the MTFs. Early resource-sharing initiatives had been small, e.g., a radiologist, nurse practitioner, nurse anesthetist, technicians. But at the David Grant Medical Center, for example, resource-sharing expenditures more than tripled over the period June 1989–October 1990. At the 814th Strategic Hospital at Beale Air Force Base, resource-sharing agreements in family practice, pediatrics, and social work caused a sixfold expansion in resource sharing over the last half of 1990.

LONG-TERM PROBLEMS

Beyond the short-term delays, the resource-sharing effort continued to be hampered by less tractable, longer-term problems. These included uncompensated burdens on the MTFs and inherently strained relations with uniformed providers.

The Burden on the MTFs

Increased Demand for Ancillary Services. As mentioned above, adding civilian providers to military hospitals through resource sharing has increased the burden on ancillary services, especially radiology and laboratory, but also pharmacy, support staff, nursing, and patient records. The overall workload increase (patients returning to the MTF) attributable to CRI is unclear, particularly in light of such complicating factors as new facilities (at Travis and Naval Hospital San Diego), base closure in overlapping catchment areas, and—in the last half of 1990—heavy deployment for Desert Storm. However, staff at a partnership site calculated that the addition of an orthopedist and obstetrician increased workload in a radiology department 10 percent and 5 percent, respectively. One laboratory attributed a 30 percent workload increase to resource-sharing obstetricians. This laboratory also ran a check on tests ordered by military and civilian providers and concluded that the primary-care civilian doctor requested two times the number of laboratory tests as his military counterpart. Measuring the effect of resource sharing on a pharmacy's workload is nearly impossible because data on use by beneficiary category are usually nonexistent. One military pharmacy head determined that civilian physicians order one more prescription per patient than military providers. MTFs also expected that civilian providers might increase the pharmacy's workload because the pharmacy staff would have to spend time to train the civilian doctors about the MTF formulary, i.e., there would be more phone calls required to civilian providers to straighten out prescription requests. However, increased pharmacy burden did not materialize to the extent feared, perhaps because MTF pharmacies were already being heavily used by CHAMPUS beneficiaries.[12]

Military providers are frequently frustrated by having to share medical technicians with civilian physicians brought in to augment MTF capability. Some claim productivity of uniformed providers declines under this arrangement. They also resent sharing clerks to chan-

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[12]CRI further augments MTF ancillary workloads because beneficiaries have an incentive to ask that diagnostic tests be done at the MTF (and the contractor has an incentive to encourage such use)—though there have been complaints about the timeliness of the MTFs in this regard. There is also the problem of liability: One MTF was sued over ancillary support of a civilian physician. In response, many ancillary departments have elected not to conduct tests generated by civilian providers outside the MTF.

nel and monitor patients. Sharing of medical technicians and clerks has been relieved somewhat because it is now common for civilian physicians to bring such personnel with them.

The nursing shortage—a national problem—is particularly acute in the military health care system. Depending on the specialty, civilian partnership or resource-sharing physicians can cause MTF nursing service to become overwhelmed. The addition of physicians is of great concern to a military hospital's nursing staff—especially since military nursing is governed by strict quality standards.

Resource sharing increases the MTF administrative burden. Resource-sharing providers are paid by the Plans but are supervised by the MTF. The Plans simply assumed that MTFs would monitor and assist the resource-sharing providers as they had with partnerships. Administrative effort is also required to separate the reimbursement of services rendered to CHAMPUS eligibles under resource sharing from that for active-duty personnel and Medicare eligibles.

Cost Implications. As a result, MTFs have requested resource sharing to cover the marginal costs incurred in supporting the initiatives. If CRI saves CHAMPUS costs, the federal government realizes a savings, but these savings often do not revert to the MTF or even to the military department that runs the facility. The systemic limitations of DoD regulations, budgeting, and accounting do not allow for such flexibility. Under the structure that existed during CRI, the MTF may actually incur additional operating expenses for increased facility use to bring in CHAMPUS workload. MTFs do not have the authority to take CHAMPUS funds and buy operational supplies and services, and the CRI contractor cannot give the MTF funds to buy supplies and services and bill the CHAMPUS account. It is very difficult to get additional operating funds from the major higher headquarters to expand in-house capability.

We were given numerous examples of this problem. One very successful resource-sharing project is estimated to save CHAMPUS about $4.5 million annually. But, in the process, this project generates $180,000 per year in supply costs that are not reimbursable to the MTF under present resource-sharing arrangements. Furthermore, there is no patient-level accounting system to identify the added supply costs that might be billed under resource sharing. This MTF's budget had not been increased to cover this additional resource-sharing workload. At another military hospital, a resource-sharing agreement was discontinued because the MTF could not afford the costly supplies needed to support the added resources.

Under the military resource allocation system, increased workloads in one year should lead to additional manpower and funding in the next year. However, a significant resource shortage for ancillary services has arisen because of limited operating budgets, persistent shortages of skilled medical support personnel, the built-in lag for personnel authorization, and the slow procurement system for major equipment. As mentioned above, obtaining medical support is also significantly affected by the Civil Service wage scale, which often prevents MTFs from being able to compete for civilian medical personnel. Hiring freezes and military personnel reductions have also reduced hospital support staff.

As a result of the uncompensated costs, some senior MTF administrators did not believe that CRI provides an incentive for them to participate. As one officer put it, "My quarrel is not with the goals of CRI, but with the way the demonstration has been structured and with the

incentive system. There are no rewards for military medicine for the extra work CRI entails—but only for the contractor." For MTF staff who needed an explicit incentive, enthusiasm for the program lagged and they did not support it. At sites where there was skepticism of CRI, some features—e.g., the HCF function—took two years to become effective.

Thus, while MTF resource-sharing planners did not at first always consult the support/ancillary departments, it quickly became clear that those departments' abilities to meet the needs of additional clinicians could not be taken for granted. Their views were needed to determine what effect adding providers would have on hospital operations. Later resource-sharing agreements better reflected the incremental resources associated with MTF patient recapture.[13]

Other Burdens. Resource-sharing agreements burden MTFs in ways that do not relate directly to the MTF budget for ancillary services. For example, space constraints, e.g., examining rooms, have been an even less tractable problem. In many MTFs, space for examining rooms and offices has been taken over by resource-sharing physicians, causing resentment among military providers.

Civilian physicians operating within the MTF can also draw down the Supplemental Care budget of the MTFs. This occurs when they refer patients outside the MTF for tests. CHAMPUS will not cover these costs unless the patient is disengaged[14] to a civilian provider outside the MTF. It might be worth exploring whether CHAMPUS regulations can be amended so that CHAMPUS would cover the diagnostic costs of patients who have not been disengaged from the MTF; obviously, disengagement threatens continuity of care. As in the case of ancillary services, the military departments have not always recognized the need to supplement the MTFs' Operations and Maintenance budgets to cover these costs, even though there can be a saving in CHAMPUS costs.

Quality of Care and Relations with MTF Practitioners

Problems have also arisen in the interface between resource sharing and MTF practitioners, particularly in relation to quality and continuity of care. For the most part, institutional interactions regarding quality of care have been constructive. Plans have coordinated QA activities with MTFs as needed, routinely forwarding case details about grievances and quality issues to MTFs for their handling. Conversely, MTFs have sought Plans' guidance on QA methods and protocols and have alerted the Plans to quality problems involving network or resource-sharing providers that, in one instance, prompted an on-site quality survey of such providers.

However, civilian physicians who practice only part-time in the MTF leave gaps in care when they are not present, particularly in the case of patients who need frequent attention. The same is true of part-time or full-time civilian physicians who leave the MTF permanently. In either case, the civilian may not make adequate provision for follow-up, or there may be no

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[13]Resource sharing cannot be used, however, to furnish an additional sum of money to an MTF to spend on unspecified ancillary support for resources provided.

[14]Released from further MTF responsibility for funding a specific episode of care.

one with the skills to follow up.[15] When uniformed providers can and do fill in, the result is a disruption in continuity of care and increased burden on the military practitioners.

Although a formal credentialing process is used to certify the quality of civilian providers, it does not address differences in practice style and process. MTF providers are skeptical of those who do not practice medicine under military regulations and are inclined therefore to question the procedures of their civilian counterparts. Such perceptions have combined with the increased burdens and the difference in salary between civilian and military providers to create a morale problem for many uniformed providers.

But resource sharing is more likely to be the solution to problems in continuity of care. Resource sharing can alleviate the instability that rotation creates—but only with advanced information on expected MTF provider numbers and mix after the annual rotation. When resource sharing involves building on a certain mix of MTF uniformed providers, caution must be exercised in rotating those providers or a similar mix must be maintained. Consider the magnitude of the problem: 30 percent of the typical MTF's staff turn over every year. In one MTF, it reached 70 percent and devastated a family practice clinic. In another case, the primary-care clinic's appointments had to be cut back 50 percent in July—the heavy rotation month—and follow-up care had to be referred to civilian providers. The benefits of resource sharing can be lost if that kind of turnover cannot be planned for or controlled.

A concern of both administrative and provider MTF staffs has been that CRI-type programs directed at care for the CHAMPUS eligibles will decrease the MTF care available for those over 65. A partial solution has been to set aside some appointments for the Medicare group and to provide them with the reduced fees of resource-sharing and partnership providers funded outside of CHAMPUS. Sensitivity to this issue seems essential for amicable working relations among MTF administrators, physicians, and Plans' staffs.

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[15]This was a primary cause of the elimination of a resource-sharing nephrologist at Fort Ord. Staff there were uncomfortable caring for kidney patients without a specialist on the staff.

6. COORDINATING CIVILIAN AND MTF HEALTH CARE: HEALTH CARE FINDERS

The HCF was intended to improve coordination between the MTFs and CHAMPUS in the service of two goals. First, the HCF was to hold down costs by channeling patients to the most cost-effective means of treatment, with emphasis on maximum utilization of the MTF. Second, HCFs were intended to answer beneficiary concerns by improving access to and continuity of medical care and by providing information to beneficiaries about their options for care. Specifically, HCFs perform the following functions:

- Route and refer CHAMPUS beneficiaries to appropriate medical providers and/or services. As a result, the HCF contributes to the integration of MTF and civilian network and non-network providers.
- Assist with utilization management through preauthorization of certain procedures and through other activities as needed.
- Maintain contact with MTF staff in order to provide beneficiaries maximum access to and, thus, optimum utilization of the MTF facility.
- In collaboration with the Health Benefits Advisors (HBAs), provide beneficiaries with information on medical care available to them.
- Aid in the movement of medical records in fulfillment of the goal of enhanced continuity of care.
- Provide information in response to CHAMPUS beneficiary requests on Prime enrollment.

While the HCF concept has proven very useful in the management of health care for beneficiaries, it involves complex personal interactions, can be difficult and costly to implement, and requires constant education of providers and beneficiaries. In the following subsections, we elaborate on this overall point with respect to each of the HCF duties but the last. The enrollment process is addressed in Section 3. We begin, however, with a description of the CHAMPUS Service Center, which included the HCF staff and played a key role in CRI-MTF liaison. We conclude the section with a discussion of staffing and training and a description of the evolution of the HCF function.

With respect to staffing, it will suffice here to note that, in view of the medically oriented decisions the HCF needed to make, HCF positions were usually filled by registered nurses or mental health professionals. Throughout the following, it should also be kept in mind that, to carry out their functions, HCFs needed information on beneficiaries' authorization numbers, medical and claims history, use of CRI network referral services, DEERS eligibility, Prime enrollment, NAS activity,[1] and civilian network and nonnetwork providers. As reported in Section 4, the Management Information System (MIS) that would support this database did not function adequately until well into the operational phase of the demonstration. Furthermore, the computer hardware and software systems at MTFs were for the most

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[1]Recall that an NAS, or nonavailability statement, is issued by the MTF to indicate lack of inpatient capacity to treat a beneficiary, permitting coverage by CHAMPUS of inpatient treatment in the civilian sector.

part rudimentary and rigid, and could not be programmed for site-specific needs that would have been helpful in supporting the HCF referral function.

THE CHAMPUS SERVICE CENTER

The CRI contract stipulated that a liaison office be established at all MTFs in areas in which Prime was offered. These liaison offices became the CHAMPUS Service Centers. Center staff provide information on the CHAMPUS Prime and Extra programs and coordinate beneficiary health care between the military and private sectors. They are the communication link among the CHAMPUS beneficiary, the MTF Health Benefits Advisor[2] and MTF providers, and the system established to carry out the CRI. The Service Center manager is the principal CRI liaison with the MTF commander. Depending on the Plan's organization strategy and the location of the Plan's headquarters relative to the MTFs, marketing, enrollment, and beneficiary services staffs may use the Service Center as their field office location.

Staffing at the Service Centers varies among the Plans and, as Table 5 shows, is subject to the role and size of the MTF. After six months of operations, there were 85 HCFs and 20 beneficiary services representatives at Service Centers. By June 1991, the number of on-site staff was 134. These people were assisted by 105 staff members at the contractor and subcontractor home offices.

Some of the centers were aggregated in service areas or regions (these arrangements varied with the Plan and over the course of the study). Each service area has a director or manager with responsibility for the Center operations in his area. The director arranges all briefings, meetings, on-site visits, media information releases, and other activities that are requested within his service area.[3] The Service Area offices provided for a measure of decentralization

Table 5
CRI Service Center Staffing by MTF Size, April 1991

MTF size	No. of HCFs[a]	No. of Mental Health HCFs	Avg. per MTF		
			HCFs[a]	Mental Health HCFs	Other[b]
Medical centers (5) 251–270 beds	29	8	5.8	1.6	4.6
Large hospitals (3) 101–250 beds	11	3	3.7	1.0	5.0
Small hospitals (11) 10–100 beds	19	1	1.7	0.1	2.4
Clinics (9)	9	2	1.0	0.2	0.4

[a]Excluding mental health HCFs.

[b]Including Beneficiary Services representatives, Marketing and Enrollment personnel, and clerks.

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[2]The HBA is the liaison between the Standard CHAMPUS program and the MTF. Relations between the HCFs and HBAs are discussed below.

[3]Contacts with the MTF commanders and their staffs did not have to go through the service area manager. The Plans' headquarters and other on-site Service Center personnel could also initiate them.

of functions such as provider relations that might otherwise have been carried out at Plan headquarters. When Foundation eliminated its service areas and consolidated functions at headquarters in the demonstration's second year, some felt CRI/MTF relations were adversely affected.

REFERRAL

Referring CHAMPUS beneficiaries to the most appropriate and cost-effective level of health care is the principal function of the HCF. Since optimizing the use of MTF resources is necessary for cost-effectiveness, a positive relationship between the HCF and the MTF commander is vital.

Source and Target

Referrals are initiated by the need of a network primary-care provider's Prime patient to see a specialty provider. The primary care provider contacts the HCF and specifies an acceptable waiting time.[4] If the HCF finds that the MTF cannot handle the case within the time specified, the HCF assists the beneficiary in locating a specialty provider, preferably within the Prime network.

While the MTF is the preferred referral target, HCFs are also concerned that a network can be weakened if there are too few patients to both maximize use of the MTF and satisfy the network providers as to their expected patient load. The Plans must balance short-run opportunities for referrals to the MTF against long-run satisfaction and the continued participation of network providers.

HCF responsibilities include directing patients with emergency/urgent medical conditions. Referrals can be to an MTF emergency room, a network urgent-care center, their primary-care provider, or civilian emergency room, when necessary. For this task, they have access to physicians and mental health professionals for medical, surgical, and psychiatric questions. HCFs do not take full patient histories and do not give medical advice.

Naturally, the MTF does not turn away emergency cases, but under CRI it does not have to accept other referrals. The MTF commander makes the final decision on the degree to which the MTF will accept nonemergency referrals of CHAMPUS patients. Referral protocol and agreements must have his approval since MTF workload is affected. Once the commander indicates the degree to which the MTF will be open for specialty referrals, he may adjust the level to correct for under- or overutilization of MTF resources.[5] Many MTFs accept increases in referrals only if resource sharing increases to enhance MTF medical care delivery.

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[4]A CHAMPUS-eligible patient not enrolled in Prime can use the HCF referral service under the Extra option, but frequently these patients obtain the *Provider Handbook* and self-refer to a network specialist. Retirees, dependents, and survivors eligible for Medicare can also use the HCF for referrals if the HCF has time to accommodate them. Any patient can go to the MTF on his or her own initiative at any time.

[5]The commander also approves or disapproves the MTF's participation in Prime by allowing his MTF's military clinicians to be designated as primary-care providers.

Trends

In the first quarter of FY91, referrals to some MTFs and clinics increased. This increase, however, resulted from deployment of uniformed providers for Desert Storm, their replacement by reservists, and the deployment of other active-duty personnel that reduced the demand for medical services and provided more appointment availability for CHAMPUS eligibles. Figure 4 shows the trend in HCF referral activity from the beginning of CRI to the end of 1991. The increase in total referrals in the second half of 1991 parallels the increased enrollment in Prime, and the slight increase in referrals to the MTF in that period probably reflects the growth in resource-sharing agreements.

By mid-1990, the Plans reached a consensus on a CRI-wide referral goal: 93 percent of each Plan's HCF referrals were to be made to either a network or an MTF provider. Standard provider self-referrals were excluded. Referrals were short by only 1–2 percent in any given quarter and exceeded 93 percent in several periods (see Figure 4).

Prerequisites for Effective Referral

In making referrals, the HCF assesses the need for care, medical appropriateness, and availability of services within the MTF, the provider network, and nonparticipating (i.e., nonnetwork) providers. To be effective, HCFs need timely information on nonavailability of MTF services—both inpatient and outpatient. One source of this information is an MTF capabilities report maintained by the HCF supervisor. It has current information regarding the MTF's capability to provide services and procedures and the actual waiting time for them.

The Plans were hoping more specific information would be available from automated or at least centralized appointment systems at the MTFs. They hoped HCFs would be able to de-
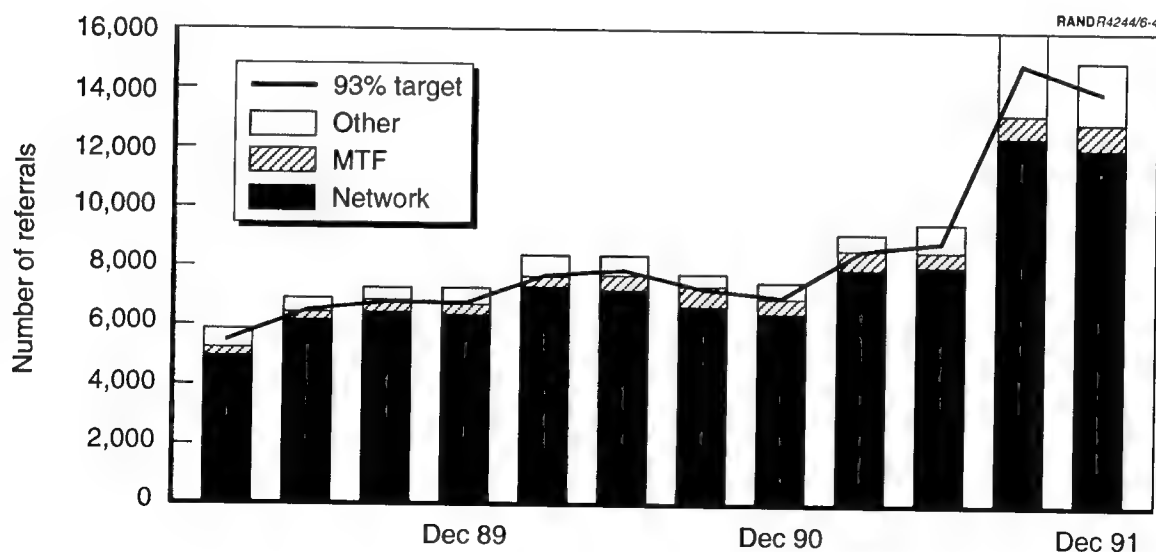

Figure 4—Health Care Finder Referrals (average per month for all CRI sites)

termine availability of appointments within a hospital's clinics and fill canceled appointments. Unfortunately, the appointments system at most MTFs proved to be an incomplete source for this information. MTF appointments systems can be centralized (MTF has a single telephone number to call) or decentralized (patient may call a specific clinic within the MTF directly). Most MTFs use aspects of both systems. Telephone systems are often marginal at the older facilities. HCFs were tied into the automated appointments system only at the hospital at March Air Force Base and Naval Hospital San Diego. At the other sites visited, the appointments system was used mainly to aid in obtaining a macro monthly picture of provider availability.

The most important element in obtaining more specific information has been establishing positive human—not computer—relationships. HCFs found they needed to contact clinic staffs regularly to determine the clinic's availability to see patients. (This also affords an opportunity to educate clinic staffs on the HCF's role.) HCFs call or "walk" the clinics—in some cases, daily—to obtain needed information. Daily contact with the clinics' appointments clerk has turned out to be necessary for awareness of changes in physicians' calendars and for a knowledge of the clinic doctors' case-mix preference. Without the physical presence of the HCF among them, clinic staffs could forget about the HCF's role in referrals, and efficiency and continuity of care could suffer as a result.

In all but one MTF, the HCFs do not process nonavailability statements, as was envisaged in the CRI proposal. The NAS function has traditionally belonged to the HBA, and MTF commanders were reluctant to press for a change. The establishment of operationally efficient procedures between MTFs and HCF staffs for NAS processing took several months. HCFs receive information from the HBAs on NASs issued and passed this information on to Plans' marketing and UM. At one MTF, the HCF also receives a form from the chief of the clinic involved in the NAS that contains the diagnosis and allows the HCF to differentiate high-cost from low-cost procedures. Such information greatly assists in UM.

For cost-effective managed care, HCFs should have been in control of all referrals from the MTF. This, however, was in the hands of the MTF Commander. Even by 1990, only a few Commanders had mandated that patients disengaged for medical care outside the MTF be referred directly and routinely to the HCF.[6] The contractor believed the autonomy of the Commander in this respect weakened the effectiveness of the referral function. However, even when Commanders have not supported mandatory referral of all CHAMPUS-eligible patients, they are, nevertheless, satisfied and dependent upon the HCF's assistance, seeing this individual's professional capability as a valuable resource for handling their beneficiary responsibility.

Educating the Providers

Educating network and MTF providers relative to the other's operation and the CRI-designed referral process has been time consuming. Both military and civilian providers are reluctant to refer patients to unknown doctors and hospitals. In one catchment area, it took a year before the MTF specialty providers were comfortable with the quality of civilian network primary-care providers and would accept referrals directly from these physicians. We heard re-

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[6]Even with mandatory referral, only Prime enrollees were obligated to use the HCF.

ports that the military providers at some MTFs suggested that patients who could not be cared for at the MTF go to specific private-sector physicians whom they knew and trusted to deliver quality care (explicit referral to private-sector physicians is against federal law). Two years after the start of CRI, there were still uniformed providers who were not well informed about CRI and the HCF or the significance of their MTF being designated as a primary-care provider. They continued to send patients to the HBA rather than the HCF. Rotation of providers exacerbated the education problem.[7]

UTILIZATION MANAGEMENT

Though not originally intended to do so, HCFs have, at many sites, assumed a role in UM, particularly in preauthorization for outpatient services and, on occasion, for concurrent review. The expanded role of the HCFs into UM was under study by the Plans within the first few months of operations. It grew out of the soon-recognized inefficient work flow between HCF and UM staff. Forty percent of HCF medical/surgical referrals—many routine—were being forwarded to UM for authorization. The review committee found that some registered nurse HCFs were probably overqualified for a sole function of triage and referral and that these HCFs expected to be involved more in UM. They found referral work boring and believed themselves qualified to handle more complex managed-care issues. The contractor approved a change, and, within the first year, HCFs were, depending on the Plan and the catchment area, preauthorizing such services as diagnostic tests, home health care services, physical therapy, and certain outpatient medical/surgical procedures.

HCFs' effectiveness at UM depends on the quality of their training and communication skills and the quality of the information on available network providers. They work closely with Plans' regional and headquarters staffs on the preauthorization function. Foundation changed the title of the HCF to managed-care specialist at certain of its MTFs. Partners, in late 1990, reverted to using their HCFs in the more traditional referral tasks, with UM carried out by staff at Rancho Bernardo.

RELATIONS BETWEEN THE HCF AND THE MTF

The subsections preceding have underscored how critical HCF interaction with the MTF staff is for the success of CRI. Early assessments of HCF effectiveness at the MTFs varied widely and were characterized by the contractor after six months as average to excellent.

One source maintained that the quality of the relationship between the HCF and the MTF depended on the administrative officer assigned as the point of contact. Higher-level administrative points of contact, with more health service experience, influenced operations of CRI more positively. At some MTFs, the HCF is seen as an extension of hospital administration at the Commander level; at other military hospitals, the HCF interacts only with the lower-ranked staff. At sites where there were suspicion and misunderstanding, the data needed by the HCF to manage patients efficiently—e.g., NASs and disengagement notices—have been neither systematic nor timely.

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[7]Note that rotation would not be a problem for provider education if CRI were implemented nationwide.

For the most part, HCFs are highly regarded by MTF administrators—even staffs at the MTFs who resented CRI respected the HCF. Many Commanders believe patient care has improved because of the work of the HCF and other CHAMPUS Service Center staff. One MTF Commander, for example, saw the CRI network as an extension of the MTF—like an umbrella—that can provide consistent quality medical care not available at the MTF. Patients can be kept within this network and their treatment successfully tracked.[8]

Smaller MTFs see the HCFs as assets because of their effectiveness in getting patients treated in the civilian sector at reduced costs. Medical centers were slower to recognize the value of the HCFs' function because they had larger provider staffs, frequently a good mix of specialties, and could care for many beneficiaries. But medical centers need patients for their specialty training programs, and they soon realized that HCFs referrals were a good patient source. One MTF expressed the hope that the HCF would increase uniformed-provider productivity because of their charter to place as many beneficiaries as possible in the MTF clinics.

As CRI has matured, HCFs have also interacted with the MTFs' discharge planner to place MTF patients in the most appropriate medical setting. The blueprint for a successful operation in one MTF, however, cannot necessarily be replicated in another without the enthusiasm of the principals involved. The personalities of responsible parties, the perceived incentives, presentation of the program, and its communication are very important. However, an early start would appear to be advantageous. Substantial benefits should result in most cases if the HCF function is established at the MTF several weeks prior to initiating enrollment to allow the first HCFs to interact with MTF staff and become acquainted with MTF policy and procedures.

RELATIONSHIP WITH THE HEALTH BENEFITS ADVISOR

Another important element for an effective HCF operation is a close, positive working relationship with HBAs. These individuals assist military beneficiaries with health care issues. The HBA has responsibility for interpreting the CHAMPUS program to beneficiaries, assisting with claims problems, advising on proper procedures for appeals, referring to alternative sources of assistance, and advising on the dependent dental program. The HBA also advises the MTF Commander on CHAMPUS matters, coordinates Cooperative and Supplemental Care (two programs that provide medical care for active-duty and military beneficiaries outside the MTF). Some HBAs have been given responsibility for overseeing the partnership program.

The HBAs are the field arm of OCHAMPUS. Since OCHAMPUS was not centrally included in the design and initial implementation of CRI, HBAs received inadequate information about CRI operations and goals. For some time, HBAs were unaware that CRI was responsible for Standard CHAMPUS claims, and some HBAs believed HCFs impeded beneficiary care.

The development of a positive HCF/HBA relationship has been dependent on the personalities involved. At the start of the demonstration, a few HBAs saw the HCF and CRI as a job

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[8]Line Commanders of military units saw CRI as enhancing medical care for active-duty personnel at the MTFs, thus contributing to troop morale.

threat. They resented the HCFs' higher salaries, claiming their work was as difficult and demanding and required a level of training and knowledge as great as that of the HCFs. (Actually, it is probably more accurate to compare HBAs to the CRI beneficiary services representatives than to the HCF.) CRI added to an HBA workload that had been increasing yearly. The HBA was often the first contact for beneficiary complaints and problems generated by the CRI claims issue described previously. During the early operational period, HBA involvement with the CRI-generated claims problem strained relations on occasion and worked against a positive HBA attitude toward CRI.

Sometimes, the HCF became a focal point for frustrations that HBAs had with the "system" before CRI. These frustrations were a lack of recognition at some MTFs and a uniform Government Service rating tied to a Civil Service job description. The different status the HBAs and HCFs held, coupled with a difference in office ambiance and "perks" between the contractor and the military facility, at some sites deterred harmony.

The degree to which Standard CHAMPUS needed to be integrated into the design of the managed-care plan was not understood by the contractor, Plans, DoD, or OCHAMPUS until well into implementation. The HCFs needed much more background and training than they got in Standard CHAMPUS protocols and procedures for the beneficiary counseling process. Once operations began, mastering the ever-changing complex CHAMPUS regulations was difficult, and the HCFs relied heavily on the HBAs for information. Indeed, HBAs have claimed that they were asked to explain CHAMPUS regulations by the Plans' headquarters staff. Clarification of these regulations can require an HBA to research complex issues. Reciprocally, HCFs do assist HBAs in the correct interpretation of the medical aspects of these regulations. They also help HBAs with medical information to assess complicated beneficiary conditions. (Unlike HCFs, HBAs generally do not have medical training.) A "veteran" HCF can be particularly helpful to a newly appointed HBA. For the most part, however, HBAs' advisory task to the HCF has added to the their already hectic schedule and has been a cause of concern even at sites where relations have been good.

To be fair, training and information for HBAs and MTF staff that would be involved in CRI operations were also deficient. A continuing concern of the Plans has been the need to educate and inform both MTF clinicians and administrators about managed care, CRI procedures and processes, and—in particular—the role of the HCF. To cite another example regarding the integration burden, consider the process required to incorporate Standard CHAMPUS modifications into CRI. In the first six months of CRI, OCHAMPUS issued 71 policy or operational changes. Incorporating these into CRI required FHC to establish its cost impacts and submit them to OSD(HA) for approval, which was time consuming. Before the CRI contract could be modified to account for them, HBAs received notification of the Standard CHAMPUS changes and informed beneficiaries in CRI catchment areas. At first, HCFs were frequently unaware of these changes. If benefits were involved in the change, beneficiaries in California and Hawaii experienced a delay in receiving them. This lack of uniformity and equity confused them—particularly those who had moved from an area where the changes were in effect. This awkward process also created frustration and misunderstanding among MTF and CRI staffs—particularly the HCF and the HBA.

The proper working environment for the HCF and HBA required their collocation in order to provide HBAs with the necessary information to promote CRI and understand its goals and procedures. Collocation also fosters a single point of contact for disengagements, referrals,

and patient management. At some MTFs, as mentioned above, it proved impossible, and HCFs were housed in trailers outside the MTF. Separation of the HCF and HBA causes problems for beneficiaries, who must often consult both and, in general, has not been an effective arrangement for achieving CRI managed-care goals. Furthermore, where space was inadequate, other CHAMPUS Service Center personnel—those involved in provider relations, marketing, and claims and appeal resolution—often had to work from either regional centers or the Plans' home offices.

Despite early faulty communication and a lack of information, in nearly all MTFs, a productive HCF/HBA relationship developed. HCFs and HBAs began to work closely together, frequently giving joint briefings to beneficiary groups on CHAMPUS and CRI and sharing beneficiary counseling tasks. They operate as a team in educating beneficiaries. While relations were being established, formal monthly meetings were common and were attended by relevant MTF staff, including the MTF Commander. Formal meetings are now less frequent, i.e., quarterly, because CRI's changes have become fewer and the relationship has matured. The need for a cooperative relationship is underscored by the fact that it has been difficult for beneficiaries to understand the differences in the HCF and HBA roles and who is the appropriate contact for a given problem.

CONTINUITY OF CARE

The HCF helps ensure that CRI fulfills its goal of fostering continuity of care in several ways. First, the HCF advises beneficiaries who enroll in Prime in their choice of a primary-care provider. This represents an improvement over the situation before CRI, when a patient could be seen by different primary-care physicians on successive visits.

Second, the HCF ensures proper consultation between MTF and non-MTF physicians. To carry out these functions, protocols and procedures were created to promote patient treatment by the same provider and provider groups. The HCF was to follow up on the treatment provided and see that medical records were shared as needed.

HCF assistance with medical records transfer is important for achieving continuity of care. Patients referred out of the MTF to a network doctor may need to have their medical charts sent to the network provider. However, the critical aspect of this record movement was not at first recognized, and it took about two years before HCFs were routinely involved in record movement. Intervention by the HCF to ensure that the appropriate medical information is sent by the referring physician provides the consultant physician with a clear medical picture of the beneficiary's current condition. The HCF also requests the consultant provider to inform the referring provider of the results of tests, procedures, diagnoses, and follow-up instructions.[9]

As noted in Section 5, civilian-network patients may ask that the MTF do their diagnostic tests. When the MTF accepts such work, the HCF has assumed an intermediary role between the MTF ancillary department and the civilian provider, transmitting test results via computer to the network provider. This arrangement was criticized as undermining the re-

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[9]While the HCF plays a coordinative role in medical-records transfer, the transmittal itself is effected by MTF staff and represents another way that CRI adds to MTF clerical burdens. MTF records cannot be sent outside the facility; they must be copied.

sponsibility of the ancillary department head to ensure that test results are given to the civilian doctors. The Plans contend that using the HCF as an intermediary lessens liability and enhances timeliness.

HCFs have also tried to foster continuity of care through their interaction with the civilian doctor and beneficiary in cases when the latter must return to the MTF for inpatient care after having been cared for on an outpatient basis in the civilian sector. This circumstance is difficult and can generate frustration, disappointment, and anger in both the civilian physician and patient. In these cases, differences of opinion can arise between military providers and their civilian counterparts over the patient's treatment.

STAFFING AND TRAINING

A senior registered nurse was employed to manage the HCF component of each CHAMPUS Service Center. The manager is the point of contact with MTF staff to implement the protocols that governed HCF operations within the MTF. The HCF function is performed by registered nurses or triage technicians. A mental health care nurse or registered nurse with mental health training is frequently a part of the HCF staff. Obtaining registered nurses for remote locations was—and continues to be—a problem but was achieved at most sites. Ex-military personnel or the spouses of active-duty Service members were hired when there was a good match of skill and background to CRI tasks. This military background proved useful in interacting with military providers, the CHAMPUS population, HBAs, and patient affairs staffs. The negative aspect of hiring military-related staff for CRI positions is that rotation of a spouse will usually require a replacement.

For the most part, HCF staffs have been stable and maintained at the planned staffing level, with adjustments reflecting workload variations. Increases occurred to handle claims problems and later additional workload. By late 1989, there were 90 HCFs operating in the demonstration area.

The mix of Service Center staff changed as enrollment activities became more routine. The increased number of enrollees brought increased referral activity, the need for more HCFs, and fewer enrollment personnel.

For HCFs to function well upon arrival at their MTFs, they needed to be informed about all aspects of medical care access, referral procedures, the demographics and specialties of the network providers, the Prime program, CHAMPUS regulations, MTF protocols, procedures, and all military medical care facilities in the catchment area. CRI field staff training had four elements: (1) an overview of the CRI program and how its components functioned, (2) how CRI staff and program components were interrelated, (3) the telephone and computer support systems, and (4) issues related to working with a military hospital or clinic.

The compressed implementation period did not allow enough time for HCF training—and training overall was found deficient—particularly for understanding the Standard CHAMPUS program. Some protocols for working within the MTF were established before operations began, but modification of these protocols and the education of the CRI civilian staff in terms of military health care routines, regulations, and tradition have needed to be ongoing. The HCF training manuals were late—the result of the extremely compressed (six months) start-up period. (Several iterations on the manual were needed for DoD review and

approval.) The Plans provided 1–2 weeks of training for the HCF supervisor. Two weeks of training on the Standard program alone—similar to that the HBA receives—are deemed necessary for anyone who is required to interpret CHAMPUS regulations. Because of cost, some HCF staff received no training. In these cases, HCF managers were the primary trainers of their staffs.

HCFs should also have been fully trained in the MTF environment before assignment. Frequently, the nurses hired for HCFs had exposure to military hospitals, but for those who did not, a learning/adjustment period was required.

As a result of all of this, some HCFs and many other CHAMPUS Service Center personnel entered their jobs generally without knowledge about CHAMPUS benefits and regulations, eligibility requirements, and the regulations peculiar to military medicine. This sometimes became a problem for beneficiaries.

EVOLUTION OF HCF FUNCTIONS

The contract required at least one HCF in each catchment area. The contractor promised full HCF operations at 12 locations, with a modified function in the six other catchment areas. "Full" implies in-person walk-in access to an HCF, modified by 24-hour free phones. By August 1988, HCF staffs were located at 25 sites (see Table 2 in Section 2).

During the early weeks of CRI operations, the HCFs' activities were largely devoted to dispensing information about CRI's managed health care options and to enrollment activities. In catchment areas where CHAMPUS Prime was not offered on August 1, 1988, HCFs were used to educate beneficiaries and providers, for enrollment, and for beneficiary services.

In the latter part of 1988, as enrollments in the CRI programs increased, the HCFs began to assume their designed role—helping beneficiaries select a primary-care physician and channeling them to appropriate medical care. However, through much of the early operations period and into 1989, they—like most CRI staff—were involved with claims-processing problems and irate providers and beneficiaries. This detracted from their role of managing, counseling, and referring Prime enrollees and those seeking network care.

By late 1990, the majority of the time of HCFs was being spent on referrals. For example, at one MTF, this was 80 percent, with 20 percent of the HCF's time devoted to claims, benefits, and miscellaneous activities. The Service Center and MTF operations had become highly integrated at most sites. As an often first point of contact, the HCFs found they had a major liaison role, educating network providers and their staffs about CRI, answering questions about the program for beneficiaries, and generally solving problems.

BRIDGING THE CRI-MTF GAP

A recurring theme of the last two sections has been that the Plans, in some instances, have found establishing effective working relations with the MTFs more difficult than they had expected. They assumed that cooperation on the part of the MTFs would be automatic since CRI was a DoD demonstration. Their early interaction with the military was neither intensive nor extensive enough to overcome apathy for CRI.

The Plans have taken a variety of approaches to create a better working relationship between military and civilian providers. By early 1989, MTF/Plans' discussions of CRI issues became routine. Reciprocal open houses, monthly meetings, joint committees to review QA protocols, exchange of resource-sharing ideas, events that brought civilian and military providers together, and newsletters began to correct the communication gap. At regional meetings, MTF and Plans medical staffs exchanged information on such topics as their facilities' medical services availability and worked out solutions to mutual problems. For multiorganizational managed health care operations, meetings that foster face-to-face personnel interactions are important.

7. LESSONS LEARNED

The following paragraphs condense the material presented in the previous sections into lessons for those tasked with conducting managed health care for the military. They are based on the extensive interviews that we conducted, and on reports, manuals, and protocols of both government agencies and the CRI contractors. They represent the opinions of the interviewees as well as our own observations.

COMMUNICATION, EDUCATION, AND TRAINING

A military managed-care program like CRI is extraordinarily complex because it must coordinate the military and civilian health care systems and accommodate a mobile beneficiary population. It requires coordination among civilian and military providers, managed-care companies, fiscal intermediaries, beneficiaries, nonclinical military staff, and federal agencies. Early in the CRI demonstration, the contractors believed that inadequate support from DoD and the MTFs hindered their implementation process. Conversely, some MTFs viewed CRI as a purely commercial venture and felt that the military was not being credited for its own efforts to improve beneficiary care. Creating satisfactory working relationships among organizations with differing perspectives requires considerable effort to establish communication channels, educate all groups about the managed-care program, and train staff in the program and the context for its implementation.

Information dissemination and exchange were inadequate at the beginning of the CRI demonstration, partly because of the excessively short implementation period. Those charged with carrying out the CRI demonstration underestimated its complexity and the time required to establish efficient operating policies and effective channels of communication among those involved.

The staffs of civilian organizations responsible for managed care in a military catchment area must understand how *all* components of the military system work. In particular, they need to be trained in the capabilities and procedures of the MTF and in the regulations associated with CHAMPUS. Civilian staff who are unfamiliar with the military system and rely inappropriately on MTF staff will generate ill will toward the new program and its implementors. Managed-care programs require additional MTF administrative effort, even in a program like CRI that relies heavily on civilian contractors. The burden on MTF personnel is lighter when, as in CRI, key civilian positions are staffed with former military medical people. However, such people are not always available, particularly in some remote areas.

Considerable effort also must be expended to educate MTF staff in the numerous aspects of a complex managed-care program such as CRI, including: the design of the program, its utilization goals, the incentives civilian providers have for discounting and joining a network, and the need to balance workload among network providers and the MTF. MTF staff in all clinical and support areas must be involved in the managed-care planning and decision process.

The program's overall goals and objectives must be clearly articulated and, more importantly, linked to anticipated benefits for beneficiaries and the MTF. Staff should be allowed

to express their views, ask questions, and receive feedback regarding their suggestions and concerns. This is important because persons from various work environments and backgrounds will be introduced to new issues and colleagues. Direct contact between key MTF and civilian personnel, and even practitioners, can be very productive. Claims processing, UM, and other managed-care functions operate more smoothly when the relevant organizations have local representatives to provide liaison with the MTF.

The implementation and operational experiences of managed-care programs at MTFs should be shared with other facilities engaged in similar programs. In most of the CRI demonstration area, forums for information exchange did not appear to exist among MTFs, even within the same service. Interservice communication and cooperation are especially important when catchment areas overlap. Dissemination of information about what works and what does not is also important for MTFs located in medically underserved areas, where establishing managed-care programs is more difficult.

Beneficiary education must be constant, since beneficiaries are probably the most difficult of the managed-care participants to keep informed. The terminology used to explain programs must be kept as simple as possible. In CRI, misunderstanding resulted from the similarity of names being used (e.g., Prime) to names of other military medical programs (e.g., PRIMUS). Various methods should be used to inform beneficiaries about changes to an existing program. Procedures for reducing beneficiary inconvenience and confusion when benefits and procedures change should be explored. Impressing beneficiaries with the need to keep their eligibility and information about location changes current is also an ongoing task. Unless this is done, benefits could be denied to an enrollee leaving a catchment area with a unique managed-care program.

Finally, the FI is a key player in any managed-care system. The problems that have always accompanied a change in FI become critical with managed care. Therefore, FI contracts should incorporate strong incentives for cooperation.

MTF INCENTIVES

The MTF command's acceptance and support of new approaches to medical care are essential in obtaining the participation and cooperation of MTF personnel. Suspicion and misunderstanding of a new program can derail—or at least adversely affect—its hoped-for outcomes. Commanders must be able to identify and then allay the fears that change creates, such as of job loss. Even if job security is not an issue, MTF administrators must be able to explain the benefits to be realized from a new program so that those affected will accept new procedures and the additional work involved in its implementation.

A primary goal of managed care is cost avoidance. Individuals responsible for its development should recognize that military clinicians and administrators have not previously had an incentive to reduce costs. Their priorities, aside from an individually rewarding medical practice, are access to high-quality medical care for military beneficiaries and the maintenance of medical training programs. Proponents of managed care hold that it enhances quality and access and can provide a better mix of patients for medical training, but this is not immediately clear to the MTFs' medical staffs. Early attention must be given to convincing them that cost avoidance does not mean low-quality medicine, reduced access to medical care, or degraded training.

ORGANIZATION AND MANAGEMENT OF MTF RESOURCES

New approaches to military health care delivery require that service commands above the MTF be aware of the complexities of managed care and its resource requirements. In some CRI catchment areas, there was inadequate provision for additional supplies for which resource sharing generated a need. (This is apart from the ancillary services problem discussed in Section 6.) This lack of planning at higher levels can jeopardize the managed-care program and the determination of its effect.

Effective MTF operations also can be thwarted by Civil Service policies. Commanders need flexibility and locally competitive rate structures to contract for personnel quickly, to correct for emergencies, and to try out staffing options without being locked into a course of action that proves ineffective. Although the speed of personnel acquisition varies among MTFs, the MTF Commanders were generally disadvantaged in working with CRI because of inflexible personnel policies. The capability for timely planning and execution in many instances requires ameliorating Civil Service union resistance to personnel service contracts for staffing managed care.

Another staffing issue concerns the allocation of military providers to MTFs. Personnel officers must become more cognizant of staff requirements in a managed-care environment. Careful planning is needed to avoid unnecessarily disrupting the balance of a catchment area's military and civilian provider network.

Base closure and consolidation also create a substantial need for organizational cooperation, planning, and communication to sustain managed care. Bases that will see an increase in their active-duty population and the corollary dependent population may be located in communities in which managed-care networks are not easily established or expanded. Military physicians reassigned from closing MTFs should be distributed so that they minimize the disruption of existing civilian provider networks. Base closure was not a major factor in the CRI demonstration during the period of our evaluation, but our interviews uncovered some concern that the Plans were not adequately included in planning for base-closure areas.

DATA MANAGEMENT, ANALYTIC CAPABILITY, AND CLAIMS PROCESSING

A considerable amount of data are needed to effectively construct and operate a managed-care program. These data are needed for decisions on resource allocation and to monitor access, quality, and cost in the program. The data must be current and include sufficient detail to allow local analysis of who delivered medical care, who received the care, and its cost. The data should include historical and current information on (1) characteristics of the population eligible for CHAMPUS and/or MTF care, (2) MTF and civilian health care use, and (3) the resources used to provide care and the costs of these resources. Many of the data must be maintained at the individual patient level so that utilization and costs can be monitored according to the clinical and other characteristics of patients. For example, MTFs and contractors must be able to determine which patients can be treated more cost-effectively in the civilian sector and which patients should be retained in the MTF. They must also be able to determine the changes in overall (MTF and CHAMPUS) costs and MTF resource requirements that result when the MTF acquires new civilian providers or its staff provides a different mix of services. In CRI, MTF and civilian managers were disadvantaged in making decisions because they lacked the needed information.

Particular data systems that currently fall short include (1) DEERS, which must find a way to collect current addresses and enrollment information for beneficiaries; (2) the Medical Expense and Performance Reporting System (MEPRS), which must provide accurate cost information at the level of detail needed for patient-level costing; and (3) a patient-level outpatient reporting system, which does not exist at all now for most MTFs.

Extreme care needs to be exercised in setting up the FI claims system for reimbursing civilian providers and beneficiaries. It should be fully tested not only for its claims-processing and payment capabilities, but also for its ability to implement UM decisions and provide accurate information on costs and utilization.

The lessons regarding education and communication that are discussed above apply here also. Besides the confusion arising from denied claims, nonpayment, and overpayment, inquiries in the early months of CRI most frequently concerned erroneous benefit explanations. Difficulties arose from rejection of previously acceptable CHAMPUS services with no explanation; from vague guidance on changes in CHAMPUS regulations and their delayed incorporation into the CRI process; or from misinformation regarding where to file claims, especially if the beneficiary had enrolled in CRI Prime and used a nonnetwork provider.

Part of the confusion resulted from the split claims system for network and nonnetwork claims. Even with superior communication links—which did not exist—uniformity in review procedures to process claims would be hard to achieve under these circumstances. If at all possible, there should be a local liaison to the claims-processing system to answer questions, explain edits and actions, and calm irate providers and beneficiaries.

An efficient process is needed in contracting with the FIs who process the claims, and their contracts need to be written with flexibility and ease of modification to accommodate managed-care program needs. Contracting with a new FI—which can occur every five years—usually causes claims payment delay and mishandling, e.g., double and triple billing of the CHAMPUS yearly deductible. This is a chronic CHAMPUS problem that is exacerbated by managed care and can generate much ill will. Claims processing deficiencies became evident early in the CRI demonstration as BCWA and FHC began to interact with other FIs and OCHAMPUS. These would have been more apparent had it not been for the complete collapse of the system used to process network claims during the first year and a half.

SCHEDULE AND TIMING OF IMPLEMENTATION OF MANAGED-CARE PROGRAMS

To deal with the complexities, the implementation period for any new program of managed care must be sufficient to establish efficient communication, develop operational systems, train staff, and establish civilian provider networks. CRI's six-month implementation period was too short to accomplish these tasks, and so operations began without the necessary elements operating efficiently.

Sufficient time must be allowed for the extra effort needed to work out special problems in areas with sparse military populations, problems with providers resistant to managed care, or problems relating to undesirable locations. A fully developed managed-care program may, in fact, not be possible in all catchment areas. Time to become familiar with the environment and socioeconomic conditions is essential to prevent wasted resources.

Very early in the implementation, information about the MTF's plans for changes in its system of health care delivery must be disseminated accurately and widely to those affected inside and outside the MTF. Competition for the military beneficiary market can be a source of potential adversarial relations between civilian and military communities and among the civilian providers of military health care. Selection of providers needs to be equitable and the selection criteria well publicized. At some locations, the Plans did not have sufficient time to bring local providers onboard for CRI.

CONCLUSION

Our final CRI interview was a little over two years after the demonstration began. By that time, there was an awareness of many of the issues raised in this section and actions were being taken to, for instance, improve communication among those involved in CRI operations, rotate hospital Commanders who had an interest and even background in managed-care concepts into demonstration MTFs, and redesign MTF-based computer systems to provide better operational data.

Still, developing managed health care techniques for military beneficiaries remains a challenge. Disruptions and loss of expertise brought about by the frequent changes in MTF staffing, restrictive government regulations, inadequate data systems, a highly mobile beneficiary population, and military deployments overseas complicate managed-care planning and operations.

Appendix

QUESTIONNAIRES

CRI INTERVIEW PROTOCOL

CRI Overview

- What are your views on CRI?
- What changes would you make in CRI implementation/operations?
- With whom on the CRI contract staff do you have contacts?
- How would you describe CRI operations at this hospital?
- What regular contacts have you had with the

    — Service Area Manager
    — Health Care Finder
    — Provider Network Physician
    — Beneficiary Service Representatives?

- What substantive areas are discussed?
- Do CRI Contractor staff attend regular meetings at the hospital?
- Have you had any meetings with the contractors where CRI interactions with this MTF were explained?
- Do you have any information on how CRI has affected the line commands?
- Do you see any situations where you would interact with the HCF?
- What were your most serious concerns in carrying out your duties before CRI?
- Do you expect these concerns to change as a result of the CRI?
- Do you understand the ramifications of being designated a PCP?
- Does CRI staff seem knowledgeable about MTF and CHAMPUS regulations?

MTF Facility Status

- What are the major facility constraints, space, equipment?
- Are there plans to renovate or build?
- When was the MTF last accredited?
- What major issues were raised at the time of that accreditation?
- What facility changes at the MTF have occurred as a result of CRI?
- What changes have occurred that were not a result of CRI?

Workload

- Are there any plans for new programs that would change the level and/or mix of care you provide?
- What have been the trends in workload at the MTF over the past two years?
- What do you expect the future trend will be?
- Has CRI affected MTF workload?
- How much time is spent on Readiness training?
- How do you monitor productivity?
- Are there any plans to change this metric?

MTF Funding

- What impacts do you foresee CRI having on your O&M or Supplemental Budget?

Ancillary and Support Services

- What is your fiscal year budget?
- Describe the staff you supervise in terms of
  - — Number of officers
  - — Number of enlisted
  - — Number of non-uniformed
  - — Number of Civil Service
  - — Number of Civilian.
- How do the tasks of the uniformed and non-uniformed staff differ?
- If there is a lack of adequate staffing, is this the result of a lack of billets or of the inability to fill the vacancies?
- Does the lack of adequate staffing affect quality of care, and, if so, how?
- How do you see CRI affecting the workload of the ancillary units?
- Are beneficiaries seen by civilian providers treated at the MTF for ancillary services?

Responsibilities—MTF Staff

- What are your responsibilities?
- Do you have any responsibility relative to CRI?
- What are the major problems in fulfilling these responsibilities?
- How is the AQCESS system being used?
- Are you scheduled to receive CHCS? When?

- Are you involved in any aspects of Resource Sharing?
- What are your responsibilities to the clinics and other medical care dispensing facilities in this catchment area?

MTF Provider Satisfaction with Military Medicine

- How did you enter military medicine?
- Have you completed your residency?
- Was this a problem?
- How many PCS moves have you had?
- Have these been troublesome to your professional development?
- How would you rate the quality of this MTF's staff—both support and physicians? Equipment?
- Do you anticipate CRI will change the case mix of your patients?
- Will this be beneficial or detrimental to your medical proficiency?
- What percentage of your time is spent in nonmedical military activities (e.g., readiness)?
- Do you intend to continue in military medicine?
- Would you share your reasons for leaving or staying?

Beneficiaries

- How large do you estimate your beneficiary population to be?
- Is this population increasing, decreasing, or changing composition?
- What percentage of the eligibles try to access the MTF?
- Are all beneficiary categories being seen at the MTF?
- Do you sense any shifts in where beneficiaries are going for care?
- What are the major problems in caring for the active-duty and the CHAMPUS eligibles?
- How has CRI affected these problems?
- Are CHAMPUS eligibles using most available MTF appointments?
- How are you trying to control for this?
- What has been the reaction of beneficiaries to CRI?
- Has CRI affected active-duty and/or Medicare referrals?
- Have referrals been mostly for CHAMPUS Extra or CHAMPUS Prime?
- Are they positive, indifferent, or negative about CRI?
- How do beneficiaries select a PCP?
- How well do you think beneficiaries understand CRI?
- Do they understand the HCF role?
- Do beneficiaries seem to understand CHAMPUS Extra benefits and how a PPO works?

- Do beneficiaries understand the PCP concept?
- What problems have there been with the HCF and PCP concepts?

DRGs

- What is the status of DRG implementation?
- What data are you collecting for DRGs?
- What do you expect to happen to the MTF's budgets as a result of DRGs?
- Have there been any changes in operations to accommodate the DRG system?

Resource Sharing (RS)

- What is the current status of Resource Sharing?
- Have you been involved in any aspects of RS?
- Who is responsible for initiating Resource Sharing?
- Who is responsible for the cost/benefit analysis of RS proposals?
- What problems have there been in negotiating RS agreements?
- What issues of RS take the most time to resolve?
- What are your major concerns about RS?
- What are the issues in utilization of shared resources to care for non-CHAMPUS beneficiaries?
- Do you anticipate developing a system for monitoring the effect of Resource Sharing on the MTF workload?
- What benefits do you foresee Resource Sharing having for the MTF or your operation?
- Do you think Resource Sharing is a good idea?
- Has Resource Sharing replaced partnerships?

Partnership Agreements

- What partnership agreements are in place?
- What partnership agreements are in the pipeline?
- Who is responsible for initiating partnership agreements?
- How have you solicited candidates for these agreements?
- Do partnerships bring their own support staff?
- What are the partnership discounts?
- Do you receive information from OCHAMPUS regarding claims paid by specialty and CHAMPUS allowable?

- Are discounts the same for non-CHAMPUS patients as they charge CHAMPUS?
- Are the discounts more or less than what CRI contractors are negotiating?
- Have you estimated the impact of partnership agreements on the workloads of the lab, pharmacy, supplies, support, nursing, etc.?
- How do you verify credentials?
- Have there been any credentialing or quality assurance problems with non-uniformed providers working in this hospital?
- Have there been morale problems with military staff as a result of civilian physicians working at this MTF?

Contract Providers

- What contract providers do you have?
- How easy has it been for you to find civilians to work in the MTF under either Government Service (GS) or contract arrangements?
- What limitations does the GS have in acquiring civilian providers on contract providers?

Provider Networks

- How familiar are you with the network hospitals? Specialists?
- Did they include providers with whom the MTF has had previous ties?
- Did MTF staff have any input in selecting network providers?
- Are there civilian providers omitted that you would have wanted included?
- Are there civilian providers included that you would have wanted excluded?
- Does the existence of networks change referral patterns?
- Do you believe the CRI network includes providers of different quality from providers previously providing CHAMPUS care?
- Will active-duty (supplemental) and Medicare referrals be affected by the CRI network?
- How would you rate the quality of the physicians and hospitals in the CRI provider network?

Health Care Finder

- Do you interact with the HCF?
- What other MTF staff work with the HCF?
- How would you characterize the relationship between MTF staff and HCF?
- Do you receive all the information and support you need from CRI staff?
- How often do HCF and MTF staff meet?

- What is on the agenda for the meetings?
- Have HCF staff and HBAs developed a workable relationship?
- Who is doing what—NAS and information on CHAMPUS?
- What arrangements have been made for the HCF to obtain information about appointment availability at (1) this MTF and (2) other MTFs?
- Has the procedure for making appointments changed as a result of HCF operations?

Utilization Review (UR)

- What is the status of utilization review at the MTF?
- Has MTF ever attempted any type of UR?
- Do you plan to develop UR protocols?
- Are uniformed providers aware of the UR policies that CRI enrolled patients they refer out of the MTF must follow, e.g., precertification?
- What will you do if beneficiaries come to the MTF for specialty care that was denied by the CRI staff?

Quality Assurance (QA)

- What are the parameters of the MTF's QA program?
- Are you familiar with the QA program and requirements of the CRI contractor?
- Has your ability to detect medical care quality problems and improve quality been better or worse under CRI?
- Do you expect to be involved in QA reviews of patients referred by MTF primary-care physicians to civilian specialty providers?
- Have there been any QA problems as a result of civilian providers working in the MTF?
- Have you reported to the CRI contractor quality-of-care problems detected in patients who return from network providers to the MTF?
- Do you foresee any problems in assuring quality under RS agreements?

Continuity of Care

- Has CRI changed civilian referrals? In what way?
- Has continuity of care been a problem for patients seen only at the MTF or both at the MTF and in the civilian sector?
- Has CRI done anything to improve continuity of care? How?

Marketing/Enrollment

- Over the past year how would you characterize the marketing effort?
- Do you believe that marketing materials were effective in explaining CRI programs?
- Did the MTF play any role in marketing for CRI—advice, liaison, participating in meetings, or fielding inquiries?
- How much beneficiary interest in CRI has there been?
- What are the questions being asked about CRI?
- Has there been active enrollment?
- What are the main reasons beneficiaries enroll?
- Are beneficiary choices regarding a primary-care provider creating any problems for the MTF?
- At what functions are beneficiaries being recruited?
- Are enrollees who pick the MTF for their PCP beneficiaries who have already used the MTF for medical care?
- Have you received any feedback from beneficiaries on how effective the marketing materials were?
- What has been the role of MTF personnel in the marketing effort?
- Would you like the MTF staff to have more or less of a marketing role? Why?
- What are the most common questions asked about CRI?
- What are the main reasons for beneficiary participation in CRI?
- When/how are beneficiaries referred to the HCF?
- Provider Network: Besides the claims problems, what have you heard from providers in the network regarding their satisfaction with CRI?

Nonavailability Statements (NASs)

- Has there been an increase/decrease in the number of NASs issued over the past year?
- What are the reasons?
- What are the guidelines for denying, granting, an NAS?
- How are NASs processed?
- Who initiates the NAS?
- Who is involved in NAS processing?
- Are NASs reviewed retrospectively?
- Who signs off on the NAS?
- How is NAS retrospective information used?
- Are the procedures the same for issuance of NASs for Mental Health as for medical/surgical care?

- Have you encountered any problems so far with NAS procedures?
- Do beneficiaries come to you if they have had an NAS denied?

Appointment System

- How does your appointment system work?
- Is the appointments system centralized or decentralized?
- What rules govern the schedule of appointments to the clinics?
- How do you currently keep abreast of appointment availability in the clinics?
- If a beneficiary comes in needing care, how do you determine whether MTF can take care of him or her?
- How and from whom do you obtain current information on appointment availability?
- What types of appointments do you make (same day, return, or active-duty CHAMPUS eligible)?
- Are appointments made in person or at home?
- Has the way MTF makes appointments changed at all because of CRI (HCF role)?
- Have satisfactory arrangements been made for the HCF to obtain information about appointment availability at this MTF?
- Have HCF staff and the Appointments Desk developed a positive working relationship?
- Who is doing what regarding information on scheduling appointments?
- Have there been any problems with appointments and the HCF working together?

HEALTH CARE FINDER INTERVIEW QUESTIONS

HCF Staff

- How large is the staff?
- Is the office adequately manned?
- Has staff increased or decreased since August 1988? Why?
- Has there been much turnover?
- What are staff members' backgrounds?
- What is the nature/duration of training for new staff?
- What additional training have HCFs had?

HCF Activities

- How is your staff's time being spent?
- How much time is devoted to telephone inquiries, in-person inquiries, outside marketing activities, enrollment, referrals for MTF care, referrals to civilian providers, and utilization management?
- Have you handled any emergency calls?
- What other services do you provide?
- Has the nature of your duties changed?
- Do you expect them to change in the future?

HBA/HCF Interface

- How would you describe the working relationship you have with the HBA?
- Do you regularly refer beneficiaries to the HBA, and vice versa?
- What issues have come up that need clarification and/or resolution?
- How were they handled?

HCF/MTF Staff Liaison

- Besides the HBA, with whom are you in regular contact at the MTF? About what?
- What has been your experience in implementing formal coordination and communication protocols with military and civilian health care providers?
- Are the data provided on MTF operational capability reports sufficient for you to make medical appointments?
- Do you attend any MTF meetings?

HCF/UM Duties

- What are the UM procedures HCFs perform?
- What is your role in utilization management: precertification, second opinion, concurrent review, retrospective review, and/or authorization for specialty and inpatient care for Prime enrollees?
- What sorts of cases have required this contact to date?
- What problems have you encountered in UM review?
- How were these problems resolved?
- What is the appeals process when requests for specialty care and inpatient care are denied?
- Have you discussed with the MTF primary-care physicians their role under CHAMPUS Prime?

HCF Mental Health

- Is there a dedicated Mental Health HCF on your staff?
- Under what circumstances is a PCP contacted in the referral of a patient for mental health services?

HCF Provider Network Interface

- What is the procedure for preauthorization?
- What has been your experience with PCPs requesting specialty care for patients?
- Do you make appointments with network providers, or do you give the beneficiaries names and phone numbers of appropriate physicians?
- Have you been involved in transmitting records between the MTF and network providers?
- How well does this work?
- Have you had any other interactions with network providers—other than appointments and record transfers?

MIS/DEERS

- Do you have/use a DEERS terminal?
- Have answers to inquiries of DEERS been received promptly and with accuracy?
- Who on your staff handles these inquiries?
- What mechanisms exist for handling problems with DEERS?
- Is the CRI MIS operating effectively?
- Are there plans for a different MIS?

SERVICE AREA MANAGER INTERVIEW QUESTIONS

Marketing

- What are your current marketing plans?
- Did the marketing approach change after the implementation of CRI?
- What news media are being used?
- What are the future plans for marketing?
- A common reaction from the MTFs was that early marketing was not aggressive enough; has the strategy changed?

Enrollment

- What is the current Prime enrollment?
- Is there an enrollment goal?
- What information did you use to target enrollment?
- What are the goals based on?
- Have the goals been met?

Beneficiary Services

- What problems, questions, have beneficiaries had with the CRI concepts, managed health care, Prime, and/or Extra?
- What seems to be the biggest selling point?
- What is the structure of the beneficiary service office?
- Has its role of beneficiary services changed?
- Where are beneficiary services located?
- What determines the placement of supervisors and representatives?

Continuity of Care

- Have there been problems in moving beneficiaries between the MTF and civilian providers?
- What mechanisms are in place to ensure continuity of care?

Grievances/Fraud/Abuse

- How many grievances, fraud/abuse cases, have there been?
- What are some examples of these cases?

Health Care Finder

- How successful have HCFs been in channeling patients into the MTFs?
- What problems have there been?
- How have they been resolved?

Appointments

- What differences are there in the way appointments are handled across MTFs?
- Which MTFs are exemplary?
- Which MTFs are not functioning well?
- Have the conditions for the effective handling of appointments been identified?
- What are they?

MTFs

- With whom do you regularly interact at the MTFs?
- What changes in coordination/collaboration would you like to see?

Resource Sharing

- What RS discussions are under way at the MTFs?
- What prevented RS implementation?

Other Data Processing

- What data processing problems exist with enrollment, DEERS, and other CRI MIS systems?

Network Hospitals/Physicians Issues

- How has the network been developed?
- Are there ongoing efforts?
- How many Physicians/Hospitals are in your network?
- How does this compare with what was targeted?
- How are provider qualifications checked?
- Are all providers credentialed?
- Where are the gaps in coverage?
- Are you still recruiting network providers?
- What is the status of provider relations?

- How do you educate providers?
- Was there any reluctance on the part of pre-CRI providers to participate in CRI? If so, how was it handled?
- What are the major problems in getting providers to adhere to CRI managed-care protocols?
- Have the MTFs provided input in selecting network providers and hospitals?
- What has been the response of providers to the delayed claims payments?
- How is this problem being handled?

Quality Assurance

- What is the staffing of QA?
- How are protocols and problems handled?
- How is QA handled with hospitals not in the network?
- What plans are there for informing MTFs on quality issues or problems?

Utilization Management

- How many staff members are involved in providing UM for CRI?
- What are the tasks of this staff?
- To whom does the UM staff report?
- How is UM handled for hospitals not in the network?
- Is there a committee that provides UM oversight?
- What is the function of the UM Committee?
- What criteria are used in retrospective review? Concurrent review?
- How is the information from retrospective reviews used?
- Are there panels for second opinions?
- How are they organized?

Case Management

- How is case management organized?
- How does case management operate?

Mental Health (MH)

- What protocols exist for MH?

- How is the staff handling MH structured?
- How are mental health cases channeled, reviewed, and managed?
- How are MH, QM, and UM handled?

Partnerships

- Are the CRI contractors informed about MTF partnership negotiations before they are signed?
- Have the MTFs been able to negotiate adequate discount rates?
- Is money being lost on partnerships? Is it significant?
- From the CRI contractors' perspective what have been the problems with partnerships? Cost? Quality? Monitoring?